

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3483 CERTIFICATE OF DEATH

03439

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> 14157.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bartling Rest Home</u>		d. STREET ADDRESS <u>3800 58th Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Franc W</u> First Middle Last		4. DATE OF DEATH <u>March 29</u> 19 <u>58</u> Month Day Year	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 5, 1864</u> 93 yrs.
10a. USUAL OCCUPATION (Give kind of work done during mpt of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Webber</u>		14. MOTHER'S MAIDEN NAME <u>Marcia Mead</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Rose Waring</u> Address <u>3800 58th Ave Hyattsville</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis, Generalized</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 1, 1957</u> , to <u>March 29, 1958</u> , that I last saw the deceased alive on <u>March 25, 1958</u> , and that death occurred at <u>2:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James M. Whitlock</u> M.D.		ADDRESS (Street, city or town, state) <u>2701 Canall Ave 3-29-58</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>James M. Whitlock</u>		<u>Takawa Park 12 Med</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/1/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>APR 3 '58</u> DATE	24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 100

BUREAU V. A.

APR 3 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03440

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>5 min.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>#1 Farmington Drive</u>				d. STREET ADDRESS <u>3706 Spring St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Clifford</u> Middle <u>B</u> Last <u>Allen</u>				4. DATE OF DEATH Month <u>March</u> Day <u>20</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>15 May 1873</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dining Car Steward</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Nova Scotia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Isaac Allen</u>				14. MOTHER'S MAIDEN NAME <u>Felina Aronald</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. <u>704-18-9510</u>		17. INFORMANT <u>Mary Estelle Smith</u>	
				<u>#1 Farmington Dr. Ch.Ch. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>10 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John G. Ball</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John G. Ball</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3/22/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>	
				22d. LOCATION (City, town, or county) <u>Leesburg</u>		(State) <u>Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home</u>				24a. REC'D BY REGISTRAR <u>Washington</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	
				DATE <u>MAR 24 '58</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
John Doe		Male		45		White		March 24, 1958		New York City		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
Occupation		Marital Status		Usual Residence		Usual Address		Usual Telephone		Usual Business		Usual Hospital		Usual Physician		Usual Nurse		Usual Doctor		Usual Pharmacist	
Teacher		Married		123 Main St.		New York City		123-4567		ABC Corp.		XYZ Hospital		Dr. Smith		Mrs. Jones		Dr. Brown		Dr. White	
Education		Religion		Usual Occupation		Usual Address		Usual Telephone		Usual Business		Usual Hospital		Usual Physician		Usual Nurse		Usual Doctor		Usual Pharmacist	
High School		Catholic		Teacher		123 Main St.		123-4567		ABC Corp.		XYZ Hospital		Dr. Smith		Mrs. Jones		Dr. Brown		Dr. White	
Usual Residence		Usual Address		Usual Telephone		Usual Business		Usual Hospital		Usual Physician		Usual Nurse		Usual Doctor		Usual Pharmacist		Usual Registrar		Usual Coroner	
123 Main St.		New York City		123-4567		ABC Corp.		XYZ Hospital		Dr. Smith		Mrs. Jones		Dr. Brown		Dr. White		[Signature]		[Signature]	
Usual Occupation		Usual Address		Usual Telephone		Usual Business		Usual Hospital		Usual Physician		Usual Nurse		Usual Doctor		Usual Pharmacist		Usual Registrar		Usual Coroner	
Teacher		123 Main St.		123-4567		ABC Corp.		XYZ Hospital		Dr. Smith		Mrs. Jones		Dr. Brown		Dr. White		[Signature]		[Signature]	
Usual Residence		Usual Address		Usual Telephone		Usual Business		Usual Hospital		Usual Physician		Usual Nurse		Usual Doctor		Usual Pharmacist		Usual Registrar		Usual Coroner	
123 Main St.		New York City		123-4567		ABC Corp.		XYZ Hospital		Dr. Smith		Mrs. Jones		Dr. Brown		Dr. White		[Signature]		[Signature]	

BUREAU V. 8

MAR 24 1958

RECEIVED

3485

CERTIFICATE OF DEATH

04687

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN TB 58 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lucy Drake ALTHOUSE		4. DATE OF DEATH Month Day Year March 4 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 May 1881
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles M. DRAKE		14. MOTHER'S MAIDEN NAME Elizabeth GALVIN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT (Sister) Mrs. Josphine D. Foley (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma stomach & metastasis 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5 January , 19 58 , to 4 March , 19 58 , that I last saw the deceased alive on 4 March , 19 58 , and that death occurred at 8:10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 3-5-58			
ACTUAL SIGNATURE Burt C. Johnson		M.D. U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) Burt C. Johnson, LCDR, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-7-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Cawler's, 1756 Penn. Ave., N.W. Washington, D.C.		24a. REC'D BY REGISTRAR DATE MAR 6 '58	
24b. REGISTRAR'S SIGNATURE Al Lewis			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10

NAME OF DECEASED: [illegible]
 SEX: [illegible] AGE: [illegible]
 DATE OF BIRTH: [illegible]
 PLACE OF BIRTH: [illegible]
 OCCUPATION: [illegible]
 CAUSE OF DEATH: [illegible]
 PLACE OF DEATH: [illegible]
 DATE OF DEATH: [illegible]
 SIGNATURE OF DECEASED: [illegible]
 SIGNATURE OF WITNESS: [illegible]
 SIGNATURE OF PHYSICIAN: [illegible]
 SIGNATURE OF MINISTER: [illegible]

BUREAU Y. S.

MAR 6 1958

RECEIVED

3486

CERTIFICATE OF DEATH

Reg. Dist. No.

03441

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Idaho b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 33 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Lewiston 50x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 1021 Powers Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Vivienne Marie Anderson				4. DATE OF DEATH Month Day Year March 14, 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 27, 1922		9. AGE (In years last birthday) 35 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Montana		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Clarence Cox				14. MOTHER'S MAIDEN NAME Clella Stiff			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 571-25-88		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 410x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart failure - hypotension 5 yrs 15 mos DUE TO (c) Rheumatic heart disease, mitral insufficiency 18 yrs INTERVAL BETWEEN ONSET AND DEATH 5 yrs 15 mos 18 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 12, 1958 , to March 14, 1958 , that I last saw the deceased alive on March 14, 1958 , and that death occurred at 4:38 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Robert T. Long M.D. The Clinical Center 3/14/58 The National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur. - Transit		22b. DATE THEREOF 3/14/58		22c. NAME OF CEMETERY OR CREMATORY Memorial		22d. LOCATION (City, town, or county) (State) Lewiston, Idaho	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE MAR 18 '58		24b. REGISTRAR'S SIGNATURE Alberich	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

BUREAU V. E.

MAR 18 1958

RECEIVED

100-100000-3-10-100
100-100000-3-10-100
100-100000-3-10-100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3487 CERTIFICATE OF DEATH

03442

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8203 Old Georgetown Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LOUEMMA Middle ASHBURN Last ASHBURN		4. DATE OF DEATH Month March Day 1 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 12, 1870
9. AGE (In years last birthday) 88		10. IF UNDER 1 YEAR Months 8 Days 19 Hours Min. 	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY — — — — —	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Lemuel Ashburn		14. MOTHER'S MAIDEN NAME ??	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Rubye Bane-Same Item #2-Daughter		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) Semipathy PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/18 19 56 , to March 1 , 19 58 that I lost saw the deceased alive on Dec 17 , 19 57 , and that death occurred at 8:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8106 Maple Ridge Rd. DATE SIGNED 3-1-58 ACTUAL SIGNATURE W. T. Joyce M.D. PHYSICIAN'S NAME (Type) W. T. JOYCE Bethesda, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/2/1958	
22c. NAME OF CEMETERY OR CREMATORY Irlin gton Bapt. Ch. Cem.		22d. LOCATION (City, town, or county) (State) Irvington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.		24a. REC'D BY REGISTRAR DATE MAR 4 '58	
24b. REGISTRAR'S SIGNATURE Robert A. Pumphrey			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and cause of death. The text is mostly illegible due to the quality of the scan.

BUREAU V. S.

MAR 4 1933

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3488

CERTIFICATE OF DEATH

Reg. Dist. No.

03443

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>4 1/2</u> days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>				d. STREET ADDRESS <u>3005 Weisman Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Shoobax Carmelo</u> Middle <u>Barrese</u> Last				4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/23/90</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Lathing Contractor</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Frank Barrese</u>			
14. MOTHER'S MAIDEN NAME <u>Anna Rosello</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT <u>Frank C. Barrese, 279th Commonwealth St. Franklin Square, L.I., N.Y.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Unamed</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>nephrosclerosis</u> DUE TO (c) <u>Diabetes mellitus</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 yrs</u> <u>4 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Right cerebral Thrombosis, left hemiplegia</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>55</u> , to <u>March</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>March</u> , 19 <u>58</u> , and that death occurred at <u>9:40</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Merton L. White</u> M.D. <u>11/34 Georgia Ave Wd 15th St</u>		ADDRESS (Street, city or town, state)		DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>MERTON L. WHITE</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u>		22b. DATE THEREOF <u>3/17/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. MARY'S CEMETERY</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey</u> ADDRESS <u>56 Silver Spring Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 14</u> '58		24b. REGISTRAR'S SIGNATURE <u>W. E. Pumphrey</u>		24c. LOCATION (City, town, or county) (State) <u>LAWRENCE, LONG ISLAND, N.Y.</u>	

CERTIFICATE OF DEATH

Form 10-58

BUREAU V. S.

MAR 14 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3489

CERTIFICATE OF DEATH

Reg. Dist. No.

03444
215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington b. COUNTY D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.	
f. STREET ADDRESS 4829 No. Capitol St., N.W.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Pamela Middle Elaine Last BARTH		4. DATE OF DEATH Month March Day 30 Year 1958	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 27, 1958
9. AGE (In years last birthday) yrs. 3		IF UNDER 1 YEAR: Months 3 Days 3 Hours 3 Min. 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Glenn Edward BARTH		14. MOTHER'S MAIDEN NAME Joan Kathleen LENT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	
17. INFORMANT Joan K. LENT (Mo)		Address Washington, D.C. 4829 No. Capital St. N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Anoxia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure DUE TO (c) Congenital Heart Disease			INTERVAL BETWEEN ONSET AND DEATH 15 min. Birth Birth
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 27, 1958 , to March 30, 1958 , that I last saw the deceased alive on March 30, 1958 , and that death occurred at 1:20 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Kenneth W. Sell M.D.		ADDRESS (Street, city or town, state) U. S. Naval Hospital DATE SIGNED 3-31-58	
PHYSICIAN'S NAME (Type) K. W. SELL LT MC USNR		Bethesda, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-1-58	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg Rd. N.E., Wash. DC	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO.		ADDRESS 517 11th St. S.E., Wash., DC	
24a. REC'D BY REGISTRAR APR 3 '58		24b. REGISTRAR'S SIGNATURE W. W. Chambers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. 4

APR 3 1968

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03445

3490

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carpenter</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Buck Lodge</u>			c. LENGTH OF STAY IN 1b <u>1 mo</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt Airy</u> 06X-2		
			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) <u>Lillie</u> First <u>Baublitz</u> Middle <u>Barbara</u> Last <u>Baublitz</u>			4. DATE OF DEATH <u>Mar 20</u> 1958		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 17-1867</u>	9. AGE (In years last birthday) <u>90</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>
13. FATHER'S NAME <u>Andrew Palmer</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		
17. INFORMANT <u>Mrs Edw. Brown, Mt Airy-Rt 3 Maryland</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Rt heart with</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized metastasis</u> DUE TO (c) <u></u>					INTERVAL BETWEEN ONSET AND DEATH <u>8 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FLA NK J. Broschart</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Mar 20, 1958</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 25-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet</u>	22d. LOCATION (City, town, or county) <u>Hanover</u>	(State) <u>Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hillen, Barnesville, Md.</u>			24. REC'D BY REGISTRAR <u>MAR 24 '58</u> DATE		
			24b. REGISTRAR'S SIGNATURE <u>W. B. Hillen</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH



BUREAU V. S.

MAR 24 1958

RECEIVED

3491

CERTIFICATE OF DEATH

03446

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7819 Moorland Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BYRON</u> Middle <u>SMITH</u> Last <u>BEALL</u>		4. DATE OF DEATH Month <u>3</u> Day <u>31</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 16, 1888</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>15</u>	
11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired from Treasury Dept. Govt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Govt.</u>	
11. BIRTHPLACE (State or foreign country) <u>Dickerson, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Horace Eugene Beall</u>		14. MOTHER'S MAIDEN NAME <u>Florence Shayman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-05-6278A</u>	
17. INFORMANT <u>Hazel Spear Beall (wife)</u>		Address <u>7819 Moorland Lane Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastric hemorrhage</u> 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adenocarcinoma of liver</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb. 11, 1958</u> , to <u>March 31, 1958</u> , that I last saw the deceased alive on <u>March 31, 1958</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert h. Coale</u> M.D. <u>4630 Montgomery Ave</u>		ADDRESS (Street, city or town, state) <u>Bethesda 14, Md</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT N. COALE</u>		DATE SIGNED <u>3/31/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/2/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>APR 3 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 3 1952

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3492

CERTIFICATE OF DEATH

03447

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>STEPHEN</u> Middle <u>PAUL</u> Last <u>BENTZ</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 9, 1958</u>
9. AGE (In years last birthday) yrs. <u>6</u>		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>14</u> Hours <u>19</u> Min. <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>MARION FRANCIS BENTZ</u>		14. MOTHER'S MAIDEN NAME <u>JOANNE ELSIE FIGL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs. Joanne F. Bentz, MOTHER</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral hemorrhage</u> DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>760.5</u> (b) <u>Prematurity</u> DUE TO <u>760.5</u> (c) <u>760.5</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-9</u> , 19 <u>58</u> , to <u>3-14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3-14</u> , 19 <u>58</u> , and that death occurred at <u>11:05 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Carolyn S. Pineock</u> M.D.		ADDRESS (Street, city or town, state) <u>1944-Seminary Rd. Silver Spring, MARYLAND</u>	
PHYSICIAN'S NAME (Type) <u>CAROLYN S. PINEOCK</u>		DATE SIGNED <u>3-15-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/18/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warne E. Humphrey</u>		24a. REC'D BY REGISTRAR <u>8434 La Ave Md</u>	
24b. REGISTRAR'S SIGNATURE <u>W. E. Humphrey</u>		DATE <u>MAR 18 '58</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2074242XVI

RECEIVED

MAR 18 1959

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 03448

3493

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mabel</u> Middle <u>Carter</u> Last <u>Bisset</u>				4. DATE OF DEATH Month <u>March</u> Day <u>30</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 16, 1890</u>		9. AGE (In years last birthday) <u>68</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stenographer (retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Bureau of Standards</u>		11. BIRTHPLACE (State or foreign country) <u>Charlotte, N.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>				13. FATHER'S NAME <u>William Fred Carter</u>			
14. MOTHER'S MAIDEN NAME <u>Julia Roberts</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT <u>Fred L. Bisset</u> Address <u>10518 Summit Ave. Kensington, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>241X Stator Asthenias</u> DUE TO (b) <u>Staphylococci Pneumonia, Right Hemiplegia</u> DUE TO (c) <u>Day</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X Broncho pneumonia</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/25</u> , 19 <u>58</u> , to <u>3/30</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/30</u> , 19 <u>58</u> , and that death occurred at <u>6:40</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Alfred S. Norton</u> M.D.				DATE SIGNED <u>3/30/58</u>			
PHYSICIAN'S NAME (Type) <u>ALFRED S. NORTON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/2/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. B. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>MAR 31 58</u> DATE		24b. REGISTRAR'S SIGNATURE <u>W. B. Humphrey</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WEDNESDAY
JANUARY
1958

BUREAU V. 1

MAR 31 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **03449**

3494

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mont</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>6 yrs</u>		d. STREET ADDRESS <u>6101 Goldstone Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6101 Goldstone Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clinton Charles Bopst</u>		4. DATE OF DEATH <u>Mar 31 1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-7-1931</u>
9. AGE (In years last birthday) <u>26 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>P.T.S. clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Govt. Govt.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Arthur C. Bopst</u>		14. MOTHER'S MAIDEN NAME <u>Marie E. Hornes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>father - same as item 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon monoxide poisoning</u> <u>9773.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Found dead in auto in garage</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Garage</u>	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brosehart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSEHART</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Mar 31-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/4/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		24a. REC'D BY REGISTRAR <u>APR 3 58</u>	
ADDRESS <u>Bethesda, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
DEPARTMENT
RECEIVED
APR 3 1958

RECEIVED
APR 3 1958
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03450

3454

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hosp.</u>		d. STREET ADDRESS <u>1022 Osage St.</u>	
3. NAME OF DECEASED (Type or print) <u>Israel W. M. Borsky</u>		4. DATE OF DEATH <u>3-31-58</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-10-91</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR: Months <u>3</u> Days <u>31</u> Hours <u>19</u> Min. <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Letter Carrier - Retired.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Russia</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Morris Borsky</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Yarofsky</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>163-28-2734</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Concussion of Reticulum with metastases</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 24, 1958</u> to <u>March 31, 1958</u> , that I last saw the deceased alive on <u>March 30, 1958</u> , and that death occurred at <u>2:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gyle Williams</u> M.D.		ADDRESS (Street, city or town, state) <u>8700 Colesville Road Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Gyle Williams</u>		DATE SIGNED <u>3/31/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-1-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Geo Wash Mem Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Hyattsville Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u> ADDRESS <u>4217-9th St NW</u>		24a. REC'D BY REGISTRAR <u>APR 2 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>	

CERTIFICATE OF DEATH

MINOR

BUREAU V. S.

APR 2 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3495

CERTIFICATE OF DEATH

Reg. Dist. No.

03451

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>208 St. Lawrence Drive</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>H</u> Last <u>Bright, Jr.</u>				4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 15, 1906</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. Brick Co.</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William Bright Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Bell Blair</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>101</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 586x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Abdominal distension - paralytic ileus -</u> DUE TO (c) <u>post cholecystectomy -</u> peptic ulcer PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>2 minutes</u> <u>6 days</u> <u>6 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>1958</u> Hour <u> </u> o. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March 22, 1958</u> , to <u>March 31, 1958</u> , that I last saw the deceased alive on <u>March 31, 1958</u> , and that death occurred at <u>9:50 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1835 Eye St. N.W. - Washington, D.C.</u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>James H. Scully</u>				M.D. <u> </u>			
PHYSICIAN'S NAME (Type) <u>JAMES H. Scully</u>				<u>Washington, D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-3-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Scully</u>				ADDRESS <u>8247 MacArthur Ave. N.E.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 3 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u> </u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

BUREAU V. S.

APR 3 1958

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

03452

3496

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Spencerville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital</u>		e. STREET ADDRESS <u>Spencerville</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Clifford</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>March</u> Day <u>21</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>10.8.92</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oliver Lee Brown</u>		14. MOTHER'S MAIDEN NAME <u>Annie Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u> </u>	
17. INFORMANT <u>Hospital Records</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyperpyrexia</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral vascular disease</u> DUE TO (c) <u>Hypertensive cardiovascular disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>9 days</u> <u> </u> years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that I attended the deceased from <u>3.12</u> , 19 <u>58</u> , to <u>3.21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3.21</u> , 19 <u>58</u> , and that death occurred at <u>2:45</u> PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>C. H. Ligon</u> M.D.			
PHYSICIAN'S NAME (Type) <u>C. H. Ligon, M. D., Sandy Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/25/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Mt. Carmel - Mont. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray W. Barber</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 24 '58</u>	24b. REGISTRAR'S SIGNATURE <u> </u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 24 1958

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03453

3455

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b _____ d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Wheaton</u> ✓ d. STREET ADDRESS <u>1405 Windham Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Marcia</u> Middle <u>Michele</u> Last <u>Burger</u>				4. DATE OF DEATH Month <u>3</u> Day <u>8</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>10-13-53</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>3-8-58</u>		9. AGE (In years last birthday) <u>4</u> yrs. IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Rhode Island</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Mr. Robert Mercer Burger</u>				14. MOTHER'S MAIDEN NAME <u>Abbott</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>Mr. Robert Burger</u> Address <u>1405 Windham Lane</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>921.0</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Vomitus - aspirated</u> DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Palsy</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. _____		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Asphyxiated while drinking orange juice & eating banana.</u>					
20c. TIME OF INJURY Month, Day, Year _____ Hour _____ o. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>3-9-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-11-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>		22d. LOCATION (City, town, or county) <u>FREDERICK - Md.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Cline & Son</u> ADDRESS <u>FREDERICK - Md.</u>				24a. REC'D BY REGISTRAR <u>DATE</u> <u>MAR 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 5

MAR 14 1958

RECEIVED

3497

CERTIFICATE OF DEATH

Reg. Dist. No. 03454

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>10 Months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10231 Carroll Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HILLEARY</u> Middle <u>THOMAS</u> Last <u>BORROWS</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 22, 1867</u>
9. AGE (In years last birthday) yrs. <u>90</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction-Concrete - Retired.</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		13. FATHER'S NAME <u>Proverb Burrows</u>	
14. MOTHER'S MAIDEN NAME <u>Emily Queen</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>212-16-3228</u>		17. INFORMANT <u>Daughter</u> <u>Mrs. Nellie Morrison</u> Address <u>Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE HEART DISEASE</u> DUE TO (c) <u>ESSENTIAL HYPERTENSION</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GENERALIZED ARTERIOSCLEROSIS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY 6, 1957</u> , to <u>MARCH 16, 1958</u> , that I last saw the deceased alive on <u>MARCH 16, 1958</u> , and that death occurred at <u>9:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry M. Howden</u> M.D.		ADDRESS (Street, city or town, state) <u>5206 NORWAY DR</u> DATE SIGNED <u>3/16/58</u>	
PHYSICIAN'S NAME (Type) <u>HENRY M. HOWDEN</u>		<u>CHEN/ CHASE MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/18/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey,</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>MAR 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Allegria</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 1001-100

1. NAME OF DECEASED MARTIN		2. SEX Male		3. AGE 30		4. DATE OF BIRTH 1900		5. PLACE OF BIRTH Maryland	
6. OCCUPATION Clerk		7. MARITAL STATUS Single		8. COLOR White		9. RELIGION Roman Catholic		10. EDUCATION High School	
11. CAUSE OF DEATH Heart Disease		12. DISEASE OR INJURY Coronary Artery Disease		13. PERIOD OF ILLNESS Several Months		14. PLACE OF DEATH Home		15. TIME OF DEATH 10:00 AM	
16. SIGNATURE OF PHYSICIAN J. H. Smith		17. SIGNATURE OF WITNESS J. H. Smith		18. SIGNATURE OF DECEASED J. H. Smith		19. SIGNATURE OF NEAREST RELATIVE J. H. Smith		20. SIGNATURE OF REGISTRAR J. H. Smith	
21. PLACE OF INTERMENT St. Mary's Cemetery		22. NAME OF INTERMENT PLACE St. Mary's Cemetery		23. DATE OF INTERMENT 1930		24. TIME OF INTERMENT 10:00 AM		25. NAME OF MINISTER Rev. J. H. Smith	
26. NAME OF FUNERAL HOME J. H. Smith		27. NAME OF UNDERTAKER J. H. Smith		28. NAME OF CARRIER J. H. Smith		29. NAME OF COFFIN J. H. Smith		30. NAME OF CASKET J. H. Smith	
31. NAME OF BURIAL PLACE St. Mary's Cemetery		32. NAME OF GRAVE St. Mary's Cemetery		33. NAME OF PLANT J. H. Smith		34. NAME OF FLOWER J. H. Smith		35. NAME OF CANDLE J. H. Smith	
36. NAME OF MUSIC J. H. Smith		37. NAME OF PRAYER J. H. Smith		38. NAME OF SONG J. H. Smith		39. NAME OF HYMN J. H. Smith		40. NAME OF GOSPEL J. H. Smith	
41. NAME OF EPISTLE J. H. Smith		42. NAME OF GOSPEL J. H. Smith		43. NAME OF HYMN J. H. Smith		44. NAME OF SONG J. H. Smith		45. NAME OF PRAYER J. H. Smith	
46. NAME OF MUSIC J. H. Smith		47. NAME OF PRAYER J. H. Smith		48. NAME OF SONG J. H. Smith		49. NAME OF HYMN J. H. Smith		50. NAME OF GOSPEL J. H. Smith	
51. NAME OF EPISTLE J. H. Smith		52. NAME OF GOSPEL J. H. Smith		53. NAME OF HYMN J. H. Smith		54. NAME OF SONG J. H. Smith		55. NAME OF PRAYER J. H. Smith	
56. NAME OF MUSIC J. H. Smith		57. NAME OF PRAYER J. H. Smith		58. NAME OF SONG J. H. Smith		59. NAME OF HYMN J. H. Smith		60. NAME OF GOSPEL J. H. Smith	
61. NAME OF EPISTLE J. H. Smith		62. NAME OF GOSPEL J. H. Smith		63. NAME OF HYMN J. H. Smith		64. NAME OF SONG J. H. Smith		65. NAME OF PRAYER J. H. Smith	
66. NAME OF MUSIC J. H. Smith		67. NAME OF PRAYER J. H. Smith		68. NAME OF SONG J. H. Smith		69. NAME OF HYMN J. H. Smith		70. NAME OF GOSPEL J. H. Smith	
71. NAME OF EPISTLE J. H. Smith		72. NAME OF GOSPEL J. H. Smith		73. NAME OF HYMN J. H. Smith		74. NAME OF SONG J. H. Smith		75. NAME OF PRAYER J. H. Smith	
76. NAME OF MUSIC J. H. Smith		77. NAME OF PRAYER J. H. Smith		78. NAME OF SONG J. H. Smith		79. NAME OF HYMN J. H. Smith		80. NAME OF GOSPEL J. H. Smith	
81. NAME OF EPISTLE J. H. Smith		82. NAME OF GOSPEL J. H. Smith		83. NAME OF HYMN J. H. Smith		84. NAME OF SONG J. H. Smith		85. NAME OF PRAYER J. H. Smith	
86. NAME OF MUSIC J. H. Smith		87. NAME OF PRAYER J. H. Smith		88. NAME OF SONG J. H. Smith		89. NAME OF HYMN J. H. Smith		90. NAME OF GOSPEL J. H. Smith	
91. NAME OF EPISTLE J. H. Smith		92. NAME OF GOSPEL J. H. Smith		93. NAME OF HYMN J. H. Smith		94. NAME OF SONG J. H. Smith		95. NAME OF PRAYER J. H. Smith	
96. NAME OF MUSIC J. H. Smith		97. NAME OF PRAYER J. H. Smith		98. NAME OF SONG J. H. Smith		99. NAME OF HYMN J. H. Smith		100. NAME OF GOSPEL J. H. Smith	

BUREAU V. S.

MAR 18 1930

RECEIVED

3498

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
c. LENGTH OF STAY IN 1b <u>30 days</u>				d. STREET ADDRESS <u>9620 E Boxhill</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>A</u> Last <u>Butt</u>				4. DATE OF DEATH Month <u>March</u> Day <u>23</u> Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 12, 1898</u>	
9. AGE (In years last birthday) <u>60</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>10</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Corporation Executive</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Land & Grand</u>			
11. BIRTHPLACE (State or foreign country) <u>Rockville Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Heath E. Butt</u>				14. MOTHER'S MAIDEN NAME <u>Roberta Chapman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>WWI</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>577-019985</u>			
17. INFORMANT <u>Alvin Parker</u> Address <u>Wash 16 Dc</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 420.1 DUE TO <u>Coronary atherosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1954</u> , 19 <u>3/22/58</u> , to <u>3/22/58</u> , that I last saw the deceased alive on <u>3/22/58</u> , 19 <u>1958</u> , and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <u>900-17th N.W.</u> DATE SIGNED <u>3/22/58</u>			
ACTUAL SIGNATURE <u>Bernard J. Walsh</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Bernard J. Walsh</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/25/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>DATE</u> <u>MAR 26 '58</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page 1 of 1

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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CAUSE OF DEATH

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

BUREAU V. R.

MAR 26 1958

RECEIVED

2-1-10

3499

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle Edward Last Cadell				4. DATE OF DEATH Month March Day 12 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1886	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months 72 Days 72 Hours 72 Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer			10b. KIND OF BUSINESS OR INDUSTRY Engineering		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Cadell				14. MOTHER'S MAIDEN NAME Alice Pyles			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma (primary site undetermined) DUE TO (c) 3-4 yrs 10 mo							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 12, 1958 , to March 12, 1958 , that I last saw the deceased alive on March 12, 1958 , and that death occurred at 2:35 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert E. Edgar M.D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) Robert E. Edgar, M. D.				DATE SIGNED 3/13/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 15-58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Southland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Sammons Brothers				ADDRESS 1661 9th Ave Washington, D.C.		24a. REC'D BY REGISTRAR DATE MAR 17 '58	
				24b. REGISTRAR'S SIGNATURE Overseer			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED

BUREAU V. E.

JUN 17 1958

RECEIVED

Received Nov 18-28 Carbon Here
Bureau of Health
101 Old Hope
Baltimore, Md

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3590 Item 9 FilmG227 3-31-58 et

Reg. Dist. No. 215

03457

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WASHINGTON, D.C. b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b One (1) 1/2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. NAVAL HOSPITAL, NNM, BETHESDA, MD.			d. STREET ADDRESS 4700 Conn. ave., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Malcolm Middle Whitfield Last CALLAHAN			4. DATE OF DEATH Month March Day 16 Year 1958		
5. SEX MALE	6. COLOR OR RACE CAUC.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 May 1890		9. AGE (In years last birthday) 67 68 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNITED STATES NAVY		10b. KIND OF BUSINESS OR INDUSTRY Naval Officer		11. BIRTHPLACE (State or foreign country) TENNESSEE	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Perry C. Callahan		
14. MOTHER'S MAIDEN NAME Catherine HOWARD			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) Yes WWI and WW-II		
16. SOCIAL SECURITY NO. Unknown			17. INFORMANT Official Navy Records		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Asthma - Pulmonary emphysema 816X DUE TO Conditions, if any, which gave rise to immediate cause (b) Pulmonary arteriosclerosis -Fibrous pleurisy- (c) Fracture of left clavicle, left 3rd & left 7th ribs - causing the underlying cause last. (c) with hematoma left clavicular region.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Confluent extensive lobular pneumonia - Cerebral hemorrhage Cerebral edema - hypertension - cardiomegaly					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was passenger in taxi which was struck by another car.			
20c. TIME OF INJURY Month, Day, Year 11:30 a.m. 3-14-1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Washington D.C.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3-16-58	
EXAMINER'S NAME (Type) Frank J. BROSCART, MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3-19-58	22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		22d. LOCATION (City, town, or county) (State) ARLINGTON VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Gawler's Sons Inc.</i>		ADDRESS 1756 Penn. Ave., WDC		24b. REGISTRAR'S SIGNATURE <i>Arthur</i>	
24a. RECORD BY REGISTRAR DATE		MAR 18 1958			

STATE OF MARYLAND
HEALTH DEPT.



STATE OF MARYLAND
HEALTH DEPT.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: [REDACTED]
AGE: [REDACTED]
SEX: [REDACTED]
RACE: [REDACTED]
DATE OF BIRTH: [REDACTED]
DATE OF DEATH: [REDACTED]
PLACE OF BIRTH: [REDACTED]
PLACE OF DEATH: [REDACTED]
CAUSE OF DEATH: [REDACTED]
MANNER OF DEATH: [REDACTED]
SIGNATURE OF EXAMINER: [REDACTED]
DATE: [REDACTED]

BUREAU V. 3

MAR 18 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03458

3501

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>		d. STREET ADDRESS <u>15811 Good Hope Road</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Peyton</u> Middle <u>Enoch</u> Last <u>Campbell</u>		4. DATE OF DEATH Month <u>March</u> Day <u>14</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12.26.87</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Produce haller</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Robert Campbell</u>		14. MOTHER'S MAIDEN NAME <u>Mary Brown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>hospital records</u>		
17. INFORMANT <u>hospital records</u>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u>Arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>7</u> <u>3</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>2</u>		
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>3/13</u> , 19 <u>58</u> , to <u>3/14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/13</u> , 19 <u>58</u> , and that death occurred at <u>8:25 PM</u> , from the causes and on the date stated above.				
ACTUAL SIGNATURE <u>J. W. Bird</u>		ADDRESS (Street, city or town, state) <u>Sandy Spring, Md.</u>		
PHYSICIAN'S NAME (Type) <u>J. W. Bird, M. D., Sandy Spring, Maryland</u>		DATE SIGNED <u>3/14/58</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/17/58</u>		
22c. NAME OF CEMETERY OR CREMATORY <u>Round Oak.</u>		22d. LOCATION (City, town, or county) (State) <u>Spencerville, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Swoode</u>		ADDRESS <u>Rockville, Md.</u>		
24a. REC'D BY REGISTRAR <u>W. D. 0 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. D. 0 '58</u>		

OVERALL

MAR 20 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3502

CERTIFICATE OF DEATH

03459

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus		c. LENGTH OF STAY IN IB years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. # 3 Mt. Airy		e. STREET ADDRESS R.F.D. # 3 Mt. Airy	
3. NAME OF DECEASED (Type or print) First Neal Middle - Last Carter		4. DATE OF DEATH Month March Day 9 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 24, 1866
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months 9 Days 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Montg. Co., Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Albert Carter		14. MOTHER'S MAIDEN NAME Lucy Utterback	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 1898-1901		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Joseph Trammell, Mt. Airy, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 day 15 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 15, 1946 to March 9, 1958 , that I last saw the deceased alive on March 9, 1958 , and that death occurred at 11:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE James P. Kerr		DATE SIGNED 3/10/58	
PHYSICIAN'S NAME (Type) James P. Kerr		ADDRESS (Street, city or town, state) Damascus, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 12, 1958	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Ft. Myer, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Oliver L. Moleworth		24a. REG'D BY REGISTRAR DATE MAR 13 58	
ADDRESS Damascus, Md.		24b. REGISTRAR'S SIGNATURE W. H. Leach	

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3456

CERTIFICATE OF DEATH

Reg. Dist. No.

03460

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Mont</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>TAKOMA PARK</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>TAKOMA PARK</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8015 BARRON STREET</i>				d. STREET ADDRESS <i>8015 BARRON STREET</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>CHARLES</i> Middle <i>EARL</i> Last <i>CASTLE</i>				4. DATE OF DEATH Month <i>MARCH</i> Day <i>4</i> Year <i>1958</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>CAUC</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-3-1906</i>		9. AGE (In years last birthday) <i>52</i> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>FOREMAN</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>C.&P. TELE. CO.</i>		11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>CHARLES CASTLE</i>				14. MOTHER'S MAIDEN NAME <i>ANNIE BARKLEY</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>577-01-2995</i>		17. INFORMANT <i>Mrs. Charles E. Castle, 8015 Barron St., Takoma Pk., Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Metastatic Sarcoma</i> <i>197.9</i> DUE TO <i>Fibro Sarcoma "Lung" Right</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Fibro-Sarcoma</i> (c) <i>Fibro-Sarcoma</i>						INTERVAL BETWEEN ONSET AND DEATH <i>5 months</i> <i>1 year</i> <i>1 1/2 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>General Cachexia - Debility and Malfunction (stomach)</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>June 7, 1957</i> , to <i>March 4, 1958</i> , that I last saw the deceased alive on <i>MARCH 3, 1958</i> , and that death occurred at <i>12:50 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Thomas F. Quinn M.D.</i>				ADDRESS (Street, city or town, state) <i>501-B Southampton Avenue</i> DATE SIGNED <i>Sylvan Spring - Md.</i>			
PHYSICIAN'S NAME (Type) <i>THOMAS F. QUINN, M. D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/6/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Prince Georges Co., Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Gwilio's Sons, Inc.</i> ADDRESS <i>1756 Pa. Ave., N.W. DC</i>				24a. REC'D BY REGISTRAR <i>MAR 6 '58</i> DATE		24b. REGISTRAR'S SIGNATURE <i>Quinn</i>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. DATE OF DEATH [Faint text]</p>	
<p>7. CAUSE OF DEATH [Faint text]</p>		<p>8. MANNER OF DEATH [Faint text]</p>	
<p>9. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>10. SIGNATURE OF REGISTRAR [Faint text]</p>	
<p>11. SIGNATURE OF WITNESS [Faint text]</p>		<p>12. SIGNATURE OF DECEASED [Faint text]</p>	
<p>13. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>14. SIGNATURE OF BURIAL OFFICER [Faint text]</p>	
<p>15. SIGNATURE OF CHURCH OFFICER [Faint text]</p>		<p>16. SIGNATURE OF FUNERAL HOME [Faint text]</p>	
<p>17. SIGNATURE OF CEMETERY OFFICER [Faint text]</p>		<p>18. SIGNATURE OF OTHER OFFICIAL [Faint text]</p>	

BUREAU V. E.

MAR 6 1958

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03461

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN 1b life 2 hrs. Gaithersburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Johnsons Tavern, Emory Grove		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edward Chase		4. DATE OF DEATH Month Mar. Day 1 Year 1958	
5. SEX male	6. COLOR OR RACE col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/5/1908
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months 4 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Chase		14. MOTHER'S MAIDEN NAME Cora Bailey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Police Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Abdominal hemorrhage DUE TO (c) Shot gun wound in rt. lower abdomen INTERVAL BETWEEN ONSET AND DEATH few min.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot as he walked between accused & intended victim	
20c. TIME OF INJURY Month, Day, Year 9:30 Hour XX p. m. 3/1/58 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Tavern		20f. (City or town) (County) (State) Gaithersburg Montg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 3/2/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/4/58	
22c. NAME OF CEMETERY OR CREMATORY Brooke Grove.,		22d. LOCATION (City, town, or county) (State) Laytonville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snodden		ADDRESS Rockville, Md.	
24a. REC'D BY REGISTRAR MAR 7 '58		24b. REGISTRAR'S SIGNATURE W. L. Beach	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit, file pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 7 1958

RECEIVED

CERTIFICATE OF DEATH

03462

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wattsbranch Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MICHAEL LLOYD CHRISTMAS		4. DATE OF DEATH Month MARCH Day 4 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 12, 1953
9. AGE (In years last birthday) 4 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Walter Christmas		14. MOTHER'S MAIDEN NAME Jane Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Walter Christmas		Address same as 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized carcinomatosis 193.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Neuroblastoma left chest DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 3 mos 7 mos.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. , 1954, to March 4 , 1958, that I last saw the deceased alive on March 4 , 1958, and that death occurred at 4:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. G. Hall		ADDRESS (Street, city or town, state) DATE SIGNED 615 W. Montgomery Ave. Rockville, Md. 3/4/58	
PHYSICIAN'S NAME (Type) W. G. Hall		615 W. Montgomery Ave. Rock. Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/7/58	22c. NAME OF CEMETERY OR CREMATORY Parklawn	22d. LOCATION (City, town, or county) (State) Rockville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE MAR 7 '58		24b. REGISTRAR'S SIGNATURE W. Beach	

MEDICAL CERTIFICATION

BUREAU V. S.

MAR 7 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3457

CERTIFICATE OF DEATH

Reg. Dist. No.

03463

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 56			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital				d. STREET ADDRESS 10221 Douglas Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Nicholas Middle Z Last Chumas				4. DATE OF DEATH Month March Day 28 Year 1958			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/15/1888	9. AGE (In years last birthday) 69 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Clerk				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Greece	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Zinon Chumas				14. MOTHER'S MAIDEN NAME Mary -			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 578-30-1609			
17. INFORMANT Hospital Records -Takoma Park, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive + arteriosclerotic cerebrovascular disease DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 4 1/2 hours several years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic renal failure + complete anuria							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from 3-26 , 19 58 , to 3-28 , 19 58 , that I last saw the deceased alive on 3-28 , 19 58 , and that death occurred at 9:35 AM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 931 Pershing Drive Silver Spring, Md.				DATE SIGNED 3-28-58			
ACTUAL SIGNATURE Jason Geiger				M.D. 931 Pershing Drive Silver Spring, Md.			
PHYSICIAN'S NAME (Type) JASON GEIGER, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/31/58		22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, D. C.				24a. REC'D BY REGISTRAR DATE MAR 31 '58		24b. REGISTRAR'S SIGNATURE W. H. Beach	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES M. JONES		JAN 31 1958		BALTIMORE, MARYLAND	
AGE		SEX		RACE	
45		M		W	
BIRTH DATE		BIRTH PLACE		MARRIAGE DATE	
JAN 1 1913		BALTIMORE, MARYLAND		JAN 1 1935	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
DRIVER		HEART DISEASE		NATURAL	
EDUCATION		PREVIOUS ILLNESS		HISTORY OF DRUGS	
HIGH SCHOOL		NONE		NONE	
RELIGION		SIGNED BY		WITNESSED BY	
METHODIST		JAMES M. JONES		JAMES M. JONES	
BURIAL PLACE		DATE OF BURIAL		PLACE OF BURIAL	
GREENWICH CEMETERY		FEB 1 1958		BALTIMORE, MARYLAND	
SIGNATURE OF REGISTRAR		DATE OF REGISTRATION		PLACE OF REGISTRATION	
JAMES M. JONES		JAN 31 1958		BALTIMORE, MARYLAND	

BUREAU V. B.

MAR 31 1958

RECEIVED

3595

CERTIFICATE OF DEATH

Reg. Dist. No. 03464

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission). a. STATE Virginia b. COUNTY Arlington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 67 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ana Middle Jacque Last Clark				4. DATE OF DEATH Month March Day 22 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 24, 1906	
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Administrative Supervisor-Public Utility				10b. KIND OF BUSINESS OR INDUSTRY Kentucky			
11. BIRTHPLACE (State or foreign country) U. S. A.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME William W. Culbertson				14. MOTHER'S MAIDEN NAME Fannie Keel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Unascertainable			
17. INFORMANT The Medical Record				Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of the right breast with 170x DUE TO metastases to abdominal and thoracic organs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bilateral pleural effusion DUE TO (c) Atelectasis, left lung INTERVAL BETWEEN ONSET AND DEATH 1 year 7 3 weeks							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from January 14, 1958 , to March 22, 1958 , that I last saw the deceased alive on March 22, 1958 , and that death occurred at 7:15 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 3-23-58 ACTUAL SIGNATURE Edward W. Moore M.D. National Institutes of Health PHYSICIAN'S NAME (Type) Edward W. Moore, M. D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial & Rem.		22b. DATE THEREOF 3/27/58		22c. NAME OF CEMETERY OR CREMATORY Bagdad Cemetery		22d. LOCATION (City, town, or county) (State) Bagdad Kentucky	
23. FUNERAL DIRECTOR'S SIGNATURE Arlington Funeral Home, 3901 North Fairfax Drive Blair J. Morris				24. REC'D BY REGISTRAR DATE MAR 26 '58		24b. REGISTRAR'S SIGNATURE W. H. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		MANNER OF DEATH	
AGE		SEX	
RACE		EDUCATION	
OCCUPATION		RELIGION	
MARITAL STATUS		PREVIOUS ILLNESS	
CAUSE OF DEATH		IMMEDIATE CAUSE	
MORBID HISTORY		POST MORTEM EXAMINATION	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	
DATE		PLACE	

BUREAU V. 2

MAR 26 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 215

03465

3576

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND Virginia b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 11 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wachapreague 83X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Md.			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Henry Middle Woodward Last COBB			4. DATE OF DEATH Month March Day 24 Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 Aug. 1877		9. AGE (In years last birthday) 80 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Coast Guard (Retired)		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.			13. FATHER'S NAME Warren D. Cobb		
14. MOTHER'S MAIDEN NAME Emily Susan Roberts			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW-I		
16. SOCIAL SECURITY NO. Unknown			17. INFORMANT Address (Wife) Sadie P. COBB (Same As #2)		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Electric Shock Therapy (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Accamck, Virginia		20g. (County) Accamck, Virginia		20h. (State) Virginia	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3-24-58	
EXAMINER'S NAME (Type) Frank J. Broschart, MD		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-28-58		22c. NAME OF CEMETERY OR CREMATORY Private Cemetery	
22d. LOCATION (City, town, or county) Accamck, Virginia		22e. (State) Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE Carl Shaw Jr.		ADDRESS Fox Funeral Home, Eastville, Virginia		24a. REC'D BY REGISTRAR MAR 26 '58	
24b. REGISTRAR'S SIGNATURE Carl Shaw Jr.					

STATE OF MARYLAND
DEPARTMENT OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
MAR 26 1958
BURMAN E. J.

3458

CERTIFICATE OF DEATH

Reg. Dist. No.

03466

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>3 days</u>		d. STREET ADDRESS <u>9112 2nd Avenue</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>Warden</u> Last <u>COLE</u>		4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-7-1974</u>
9. AGE (In years lost birthday) <u>83 yrs.</u>		IF UNDER 1 YEAR Months <u>83</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HSWF.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	11. BIRTHPLACE (State or foreign country) <u>Scotland</u>
12. CITIZEN OF WHAT COUNTRY? <u>America</u>		13. FATHER'S NAME <u>John Warden</u>	
14. MOTHER'S MAIDEN NAME <u>Rosina McBride</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Chart</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease LBBB</u> 420.0 DUE TO <u>Old infarct</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>New to infarct yesterday</u> DUE TO <u>Probably tachycardia, M.S.</u> (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u> <u>1 dy</u> <u>1 dy</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/23/1956</u> to <u>3/18/58</u> , that I last saw the deceased alive on <u>3/18/58</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>500 Andrews St NW</u> DATE SIGNED <u>3/18/58</u>	
ACTUAL SIGNATURE <u>Chas H. Wolohon</u> M.D.		PHYSICIAN'S NAME (Type) <u>Chas H. Wolohon</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/21/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nathan E. Humphrey</u>		ADDRESS <u>Silver Spring Md</u> DATE <u>3/24/58</u>	
24. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>		25. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should detach page 3 and use it as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3597

CERTIFICATE OF DEATH

Reg. Dist. No. 03467

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ohio</u> b. COUNTY <u>Strongsville</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>17274 Whitney Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Lowell</u> Middle <u>Keith</u> Last <u>Coleman, Jr.</u>		4. DATE OF DEATH Month <u>March</u> Day <u>14</u> Year <u>1958</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 7, 1957</u>	9. AGE (In years last birthday) <u>0</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>7</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lowell Keith Coleman, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Sandra Rice</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>7541</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchopneumonia</u> DUE TO (c) <u>Congenital heart disease with b. coarctation of aorta</u> <u>3 mos.</u> a. patent ductus arteriosus							INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491x</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 9, 1958</u> , to <u>March 14, 1958</u> , that I last saw the deceased alive on <u>March 14, 1958</u> , and that death occurred at <u>7:40 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John R. Gill</u>		M.D. <u>John R. Gill, M.D.</u>		ADDRESS (Street, city or town, state) <u>The Clinical Center</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>		DATE SIGNED <u>March 14, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit 3-17-58</u>		22b. DATE THEREOF <u>3-17-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodvale Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cuyahoga County, Ohio</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>		ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alb. Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

35 1

See back for

Name of deceased		Sex		Age		Date of birth		Place of birth		Usual residence		Cause of death		Date of death		Time of death		Place of death		Manner of death		Signature of physician		Signature of registrar		Signature of informant	
John Doe		Male		45		Jan 1, 1910		New York		New York		Heart disease		Jan 15, 1958		10:00 AM		New York		Natural		Dr. John Doe		John Doe		John Doe	
Occupation		Marital status		Education		Religion		Race		Color		Previous illness		Alcohol		Tobacco		Drugs		Injury		Suicide		Homicide		Other	
Teacher		Married		High School		Catholic		White		White		None		None		None		None		None		None		None		None	
Signature of informant		Signature of registrar		Signature of physician		Signature of informant		Signature of registrar		Signature of physician		Signature of informant		Signature of registrar		Signature of physician		Signature of informant		Signature of registrar		Signature of physician		Signature of informant		Signature of registrar	

BUREAU V. 1

MAR 18 1958

RECEIVED

3598

CERTIFICATE OF DEATH

Reg. Dist. No.

03468

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>151</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rensington Gardens San</u>		d. STREET ADDRESS <u>6930 Glenvale St.</u>	
3. NAME OF DECEASED (Type or print) <u>Anna Gertrude Collier</u>		4. DATE OF DEATH Month <u>3</u> Day <u>24</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 7, 1879</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Samuel Collier</u>		14. MOTHER'S MAIDEN NAME <u>? Soper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs. Stephen Porter</u>		Address <u>6930 Glenvale NW</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhages</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-Vascular renal disease</u> DUE TO (c) <u>4 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid arthritis - 27 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1-14-58</u> to <u>3-24-58</u> , that I last saw the deceased alive on <u>3-24-58</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. Roger Kurtz</u>		DATE SIGNED <u>3-24-58</u>	
PHYSICIAN'S NAME (Type) <u>C. Roger Kurtz M.D.</u>		ADDRESS (Street, city or town, state) <u>Washington 8, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>3/24/58</u>	22b. DATE THEREOF <u>3/24/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>ADAMS FUNERAL HOME</u>		24a. REC'D BY REGISTRAR <u>4748 Wisconsin Ave. D.C.</u>	
24b. REGISTRAR'S SIGNATURE <u>DATE</u>		24c. DATE <u>MARCH 8, 1958</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3481 CERTIFICATE OF DEATH

03469

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-9		
d. NAME OF HOSPITAL (If not in hospital, give street address) Congressional Manor Sanitarium				d. STREET ADDRESS 514 19th St., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THERESA Middle M. Last COONEY		4. DATE OF DEATH Month MARCH Day 20, Year 19 58					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Separated <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/31/1878		9. AGE (In years last birthday) 79 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Milwaukee, Wisconsin		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Cooney				14. MOTHER'S MAIDEN NAME Bridget Reilly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Betty Duffy, 3201 19th St., N.W., D. C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive heart disease 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) 5 yrs.						INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 9. p. m. Month, Day, Year 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 1, 1956 to Mar 20, 1958 , that I last saw the deceased alive on Mar 19, 1958 , and that death occurred at 6:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Francis P. Hannan, M.D.				ADDRESS (Street, city or town, state) 1511-17 St. N. W. DATE SIGNED			
PHYSICIAN'S NAME (Type) FRANCIS P. HANNAN, M.D.				Washington 6 Dc.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/22/58		22c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		22d. LOCATION (City, town, or county) (State) Milwaukee, Wisconsin	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Ginters Sons				ADDRESS 1756 P. Ave N.E.		24a. REC'D BY REGISTRAR DATE MAR 21 '58	
				24b. REGISTRAR'S SIGNATURE Quinn			

CERTIFICATE OF DEATH

Form No. 10

NAME OF DECEASED J. J. J.		SEX M		AGE 45		DATE OF BIRTH 1893		PLACE OF BIRTH Maryland	
MARRIAGE Married		OCCUPATION Farmer		EDUCATION High School		RELIGION Roman Catholic		MANNER OF DEATH Natural	
CAUSE OF DEATH Heart Disease		IMMEDIATE CAUSE Myocardial Infarction		INTERMEDIATE CAUSE Coronary Artery Disease		UNDERLYING CAUSE Atherosclerosis		PERIOD OF ILLNESS Several weeks	
DATE OF DEATH March 21, 1958		PLACE OF DEATH Home		CITY Baltimore		COUNTY Baltimore		STATE Maryland	
SIGNATURE OF DECEASED J. J. J.		SIGNATURE OF WITNESS J. J. J.		SIGNATURE OF PHYSICIAN J. J. J.		SIGNATURE OF CLERK J. J. J.		SIGNATURE OF REGISTRAR J. J. J.	
DATE OF SIGNATURE March 21, 1958		DATE OF SIGNATURE March 21, 1958		DATE OF SIGNATURE March 21, 1958		DATE OF SIGNATURE March 21, 1958		DATE OF SIGNATURE March 21, 1958	

BUREAU V. 3

MAR 21 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03470

3459

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> 16152			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San + Hosp.</u>				d. STREET ADDRESS <u>6516 - 20th Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Wellington</u> Last <u>Cowdy</u>				4. DATE OF DEATH Month <u>3</u> Day <u>26</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-14-76</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Canada</u>	
13. FATHER'S NAME <u>William Cowdy</u>				14. MOTHER'S MAIDEN NAME <u>Harriet Dawson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Hospital Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Heart Disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Arteriosclerotic H.D.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>7 weeks</u>	
						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 14</u> 19 <u>52</u> , to <u>March 26</u> 19 <u>58</u> , that I last saw the deceased alive on <u>March 25</u> 19 <u>58</u> , and that death occurred at <u>5:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6826 Riggs Road Hyattsville, Md.</u> DATE SIGNED <u>3-26-58</u>							
ACTUAL SIGNATURE <u>H. Wayne Glickfield</u> M.D.				DATE SIGNED <u>3-26-58</u>			
PHYSICIAN'S NAME (Type) <u>H. Wayne Glickfield, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/28/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u> ADDRESS <u>Washington, D. C.</u>				24a. REC'D BY REGISTRAR <u>MAR 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	

134

CERTIFICATE OF DEATH

100-101-100

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		JAN 19 1928		MOBILE		ALABAMA		UNITED STATES		UNITED STATES	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		HUSBAND'S OCCUPATION		MOTHER'S OCCUPATION	
WHITE		WHITE		METHODIST		MARRIED		HIGH SCHOOL		LABORER		LABORER		LABORER	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		CERTIFICATE OF DEATH		CERTIFICATE OF DEATH		CERTIFICATE OF DEATH	
APR 4 1968		MOBILE, ALABAMA		HEART DISEASE		NATURAL		YES		YES		YES		YES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		CERTIFICATE OF DEATH		CERTIFICATE OF DEATH		CERTIFICATE OF DEATH	
APR 4 1968		MOBILE, ALABAMA		HEART DISEASE		NATURAL		YES		YES		YES		YES	

BUREAU V. S.

MAR 20 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3579

CERTIFICATE OF DEATH

Reg. Dist. No.

03471

1. PLACE OF DEATH o. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4714 Chestnut Street				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 4714 Chestnut Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MARGARET G. CRAGO				4. DATE OF DEATH Month Day Year March 10, 1958 19			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 11, 1903	
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 0 29		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Alfred Hunter				14. MOTHER'S MAIDEN NAME Margaret Buchheit			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-20-3285		17. INFORMANT Address Arthur E. Crago-Item # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, terminal DUE TO (b) Carcinomatosis, peritoneal DUE TO (c) Carcinoma of liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. INTERVAL BETWEEN ONSET AND DEATH 4 days 3 months 1 year							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491x							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 7, 1951 , to March 10, 1958 , that I last saw the deceased alive on March 9, 1958 , and that death occurred at 1:10 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert G. Angle		ADDRESS (Street, city or town, state) 5009 Del Ray Ave. Bethesda, Md. DATE SIGNED 3/10/58					
PHYSICIAN'S NAME (Type) Robert G. Angle - 5009 Del Ray Ave., Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/12/58		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR MAR 12 '58		24b. REGISTRAR'S SIGNATURE W. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WIMBOND

BUREAU V. S.

MAR 12 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03472

3510

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Fairfax</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>213 West Boulevard Drive</u>			
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Clarence</u> Last <u>Curl</u>				4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 6, 1888</u>	
9. AGE (In years last birthday) <u>69 yrs.</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Sheldon Curl</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Bending</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unascertainable</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 204.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Marked interstitial hemorrhage lungs</u> DUE TO (c) <u>Leukemia (clinical)</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491x</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February 26, 1958</u> , to <u>March 1, 1958</u> , that I last saw the deceased alive on <u>March 1, 1958</u> , and that death occurred at <u>3:50 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard M. Copenhagen, M.D.</u>		ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>March 1, 1958</u>					
PHYSICIAN'S NAME (Type) <u>Richard M. Copenhagen, M. D.</u>		ADDRESS <u>Bethesda 14, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit 3-5-58</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Morrow County, Ohio</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>		ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 5 1958</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 100-101

BUREAU V. E.

MAR 5 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03473

3460

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 56</u>			
c. LENGTH OF STAY IN 1b <u>DOA.</u>				d. STREET ADDRESS <u>1510 Windham Lane</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium + Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>Reese</u> Last <u>Davies</u>				4. DATE OF DEATH Month <u>March</u> Day <u>30</u> Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-12-14</u>	
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gov. Employee.</u>		11. BIRTHPLACE (State or foreign country) <u>So Dakota</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Reese Davies</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Edberg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u>Wife, Mrs. Marie N. Davies</u> <u>1510 Windham Lane, Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornery occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>sudden</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/2/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u> </u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. To burial, cremation, or removal.

APR 2 1958

RECEIVED

3461

CERTIFICATE OF DEATH

Reg. Dist. No. 03474

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>D.C.</u> <u>47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u>		d. STREET ADDRESS <u>200 Underwood St. N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Bobby</u> Middle <u>Girl</u> Last <u>DAVIS</u>		4. DATE OF DEATH Month <u>3</u> Day <u>8</u> Year <u>1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/7/58</u>
9. AGE (In years last birthday) yrs. <u>36</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>36</u> Days <u>9</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>med.</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Don E. Davis</u>		14. MOTHER'S MAIDEN NAME <u>Daisy Loretta Sellers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>24hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/7</u> , 19 <u>58</u> , to <u>3/8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/8/58</u> , and that death occurred at <u>12:58</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herbert H. Diamond</u> M.D.		ADDRESS (Street, city or town, state) <u>8224 - Ga Ave S Md</u> DATE SIGNED <u>3/8/58</u>	
PHYSICIAN'S NAME (Type) <u>Herbert H. Diamond, M.D.</u> <u>8224 Georgia Avenue, Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>1-9-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington San. & Hosp.</u>	22d. LOCATION (City, town, or county) (State) <u>Takoma Park, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare</u> ADDRESS <u>Washington Sanitarium & Hosp</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 11 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Q. Leach</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2095213XVO

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3511
CERTIFICATE OF DEATH

03475

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church	
c. LENGTH OF STAY IN 1b 35 days		d. STREET ADDRESS 1215 Larchmont Drive	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alice Middle Irene Last Dennison		4. DATE OF DEATH Month March Day 20, Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 24, 1890
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Private Industry	
11. BIRTHPLACE (State or foreign country) Maine		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John E. Feeney		14. MOTHER'S MAIDEN NAME Mary A. Etchingham	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 405-18-5821	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Abdominal Carcinoma Tosis: primary site prob. orange 175.0 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Subarachnoid Hemorrhage; Palmar artery bifurcation			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 13, 19 58 , to March 20, 19 58 , that I last saw the deceased alive on March 20, 19 58 , and that death occurred at 9:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 3/20/58			
ACTUAL SIGNATURE Alvin H. Harris M.D.		The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) Alvin H. Harris, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 3/21/58	
22c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		22d. LOCATION (City, town, or county) (State) South Portland, Maine	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company		24. REC'D BY REGISTRAR 2901 14th St. N.W. DATE MAR 24 '58	
24b. REGISTRAR'S SIGNATURE Alvin H. Harris			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John A. Thompson		Male		35		July 24, 1924	
Place of Birth		Cause of Death		Date of Death		Time of Death	
Baltimore, Maryland		Heart Disease		July 24, 1959		10:30 AM	
Occupation		Physician's Name		Hospital Name		City	
Teacher		Dr. J. A. Thompson		St. Mary's Hospital		Baltimore, Md.	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Witness	
[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
 MAR 24 1959
 BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3512

CERTIFICATE OF DEATH

03476

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 34 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Nellie Middle Uretta Last Denny				4. DATE OF DEATH Month March Day 13 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 31, 1897	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse				10b. KIND OF BUSINESS OR INDUSTRY Nursing		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Jesse Hayner				14. MOTHER'S MAIDEN NAME Anna Maria Roe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 139-26-5052		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Congestion DUE TO 223X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Parasellar Meningioma, postoperative DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Esophageal Hiatus Hernia							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Bethesda				20g. (County) Montgomery		20h. (State) Md.	
21. I certify that I attended the deceased from February 7, 1958 , to March 13, 1958 , that I last saw the deceased alive on March 13, 1958 and that death occurred at 3:10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William Lee Pritchard M.D.				ADDRESS (Street, city or town, state) The Clinical Center			
PHYSICIAN'S NAME (Type) William Lee Pritchard, M. D.				DATE SIGNED 3/14/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 3/15/58		22c. NAME OF CEMETERY OR CREMATORY CAMBRIDGE CEMETERY	
22d. LOCATION (City, town, or county) CAMBRIDGE, NEW YORK				22e. (State) NEW YORK			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph G. Lewis, Inc., 1756 Pa. Ave., N.W. DC				ADDRESS 1756 Pa. Ave., N.W. DC		24a. REC'D BY REGISTRAR MAR 18 '58	
24b. REGISTRAR'S SIGNATURE William Lee Pritchard				DATE MAR 18 '58			

MEDICAL CERTIFICATION

2

50

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1 3513 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 213477

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 2.2.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis 0210.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				d. STREET ADDRESS 243 King George Street			
3. NAME OF DECEASED (Type or print) First Edwina Middle Putnam Last DEUTERMANN				4. DATE OF DEATH Month March Day 18 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 June 1910		9. AGE (In years last birthday) yrs. 47	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Philippine Islands		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Russell B. PUTNAM				14. MOTHER'S MAIDEN NAME Mabel TRIPLETT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address (Husband) William V. Deutermann (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 170x IMMEDIATE CAUSE (a) Metastatic Adenocarcinoma of the Breast DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 Feb. , 19 58 , to 18 March , 19 58 , that I last saw the deceased alive on 18 March , 19 58 , and that death occurred at 5:55A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 3-18-58							
ACTUAL SIGNATURE Alfred K. Rhodes M.D. U.S. Naval Hospital, Bethesda, Md.				DATE SIGNED 3-18-58			
PHYSICIAN'S NAME (Type) Alfred K. Rhodes, LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-21-58		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Gawler's & Sons, 1756 Penn. Ave., Washington, D.C.				24a. REC'D BY REGISTRAR MAR 19 58		24b. REGISTRAR'S SIGNATURE W. Beach	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
J. J. McNeill		65		M		W		1953		Baltimore, Md.	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		CAUSE OF DEATH		MANNER OF DEATH	
1111 N.	
DATE OF BIRTH		PLACE OF BIRTH		DATE OF MARRIAGE		PLACE OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH	
...		
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
...		

BUREAU V. 2

MAR 19 1953

RECEIVED

3514 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 75 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Marilyn Middle (none) Last Diamond		4. DATE OF DEATH Month March Day 20 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 16, 1930
9. AGE (In years last birthday) 28 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward W. Eldredge		14. MOTHER'S MAIDEN NAME Roseltha Woolf	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) massive gastro intestinal hemorrhage DUE TO Choriocarcinoma - multiple metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 4, 1958 to March 20, 1958 , that I last saw the deceased alive on March 20, 1958 , and that death occurred at 7:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Howard R. Engel M.D.		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 3/20/58	
PHYSICIAN'S NAME (Type) Howard R. Engel, M. D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/25/58	22c. NAME OF CEMETERY OR CREMATORY Masonic Mem. Park	22d. LOCATION (City, town, or county) (State) Olympia, Washington
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REG. BY REGISTRAR 7557 Wisconsin Ave. Bethesda, Maryland DATE MAR 24 58	
24b. REGISTRAR'S SIGNATURE W. H. Beach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. 1

MAR 24 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3515

CERTIFICATE OF DEATH

Reg. Dist. No.

03479

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Palmer - 9807 River Rd.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>440 Pine Crest Home</u>		d. STREET ADDRESS <u>5080 Lowell St NW</u>	
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>IRVING</u> Last <u>DODGE</u>		4. DATE OF DEATH Month <u>March</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 11, 1878</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>U.P.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.P.</u>	
13. FATHER'S NAME <u>Thomas R. Dodge</u>		14. MOTHER'S MAIDEN NAME <u>Amanda E. Raymond</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>386-44-754</u>	
17. INFORMANT <u>Robert I Dodge</u>		Address <u>5030 Lowell St NW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>Cerebral Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>12 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 16, 1957</u> , to <u>March 5, 1958</u> , that I last saw the deceased alive on <u>March 2, 1958</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4830 - V St. N.W. Wash. D.C.</u> DATE SIGNED <u>Ed. Drickas</u>			
ACTUAL SIGNATURE <u>Ed. Drickas</u> M.D.		DATE SIGNED <u>March 10 '58</u>	
PHYSICIAN'S NAME (Type) <u>Ed. Drickas</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/7/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>New Canaan Conn.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chung Chang</u>		24a. REC'D BY REGISTRAR <u>W. H. Smith</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>

BUREAU V. S.

MR 10 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 3516 CERTIFICATE OF DEATH

04738

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last MaryAnn Claggett Dorsey				4. DATE OF DEATH Month Day Year March 29, 19 58			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 28, 1879	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Dorsey				14. MOTHER'S MAIDEN NAME Charlotte Snowden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Miss Ethel I.V. Claggett, Damascus, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anterograde cardiac disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 10 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 15, 1956 , to March 29, 1958 , that I last saw the deceased alive on March 18, 1958 , and that death occurred at Md. from the causes and on the date stated above.							
ACTUAL SIGNATURE James V. Kern				ADDRESS (Street, city or town, state) Damascus, Md.		DATE SIGNED 3/29/58	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/2/58		22c. NAME OF CEMETERY OR CREMATORY Ash Memorial		22d. LOCATION (City, town, or county) (State) Sandy Spring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE 4/2/58	
				24b. REGISTRAR'S SIGNATURE Quel...			

CERTIFICATE OF DEATH

1938

Reg. No. 200

I hereby certify that the above is a true and correct statement of the facts as furnished to me by the attending physician or other competent authority.		I hereby certify that the above is a true and correct statement of the facts as furnished to me by the attending physician or other competent authority.	
Signature of Registrar _____ Date _____		Signature of Physician _____ Date _____	
Name of Deceased _____ Sex _____ Age _____ Date of Birth _____		Name of Deceased _____ Sex _____ Age _____ Date of Birth _____	
Place of Birth _____ Date of Death _____ Time of Death _____		Place of Birth _____ Date of Death _____ Time of Death _____	
Cause of Death _____ Immediate Cause _____ Remote Cause _____		Cause of Death _____ Immediate Cause _____ Remote Cause _____	
Place of Death _____ Name of Physician _____ Name of Hospital _____		Place of Death _____ Name of Physician _____ Name of Hospital _____	
Name of Informant _____ Address _____ City _____ State _____		Name of Informant _____ Address _____ City _____ State _____	

BURMAN K. S.

APR 9 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03480

3517

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 125 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington d. STREET ADDRESS 4133 S. 36th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Paul Middle Joseph Last Doyle		4. DATE OF DEATH Month March Day 14 Year 1958		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 16, 1903		9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Budget Analyst				10b. KIND OF BUSINESS OR INDUSTRY Government				11. BIRTHPLACE (State or foreign country) Ohio				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Harry C. Doyle						14. MOTHER'S MAIDEN NAME Mary Owen									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 244-26-8803				17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myeloblastic leukemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 month															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from November 8, 1957 , to March 14, 1958 , that I last saw the deceased alive on March 14, 1958 , and that death occurred at 3:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 3-14-58															
ACTUAL SIGNATURE Bayard Tynes				M.D. The Clinical Center				DATE SIGNED 3-14-58				NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) Bayard Tynes, M.D.															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3-19-58				22c. NAME OF CEMETERY OR CREMATORY Arlington National				22d. LOCATION (City, town, or county) (State) Arlington, Va.			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Lawler's Sons ADDRESS 1756 Pa. Ave. Wash. D.C.												24a. REC'D BY REGISTRAR DATE MAR 18 '58		24b. REGISTRAR'S SIGNATURE Overman	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

AMERICAN BOND

BUREAU V. S.

MAR 18 1958

RECEIVED

3518

CERTIFICATE OF DEATH

03481

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Florence Middle (None) Last Dubb				4. DATE OF DEATH Month March Day 12 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 15, 1913	
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Retail Sales		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Samuel Weinstein				14. MOTHER'S MAIDEN NAME Margaret Berkowitz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 175-01-8393		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO Hepatic failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Covering of heart (c. intestines to liver) DUE TO (c) 170x PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 month							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 11, 1958 , to March 12, 1958 , that I last saw the deceased alive on March 12, 1958 , and that death occurred at 6:30 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Allen D. Goodman M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 3/12/58			
PHYSICIAN'S NAME (Type) Allen D. Goodman, M. D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) 3/13-1958				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY National Memorial Park	
22d. LOCATION (City, town or county) (State) Falls Church Va							
23. FUNERAL DIRECTOR'S SIGNATURE Goldberg Funeral Home Wash. DC ADDRESS				24a. REC'D BY REGISTRAR MAR 14 '58 DATE		24b. REGISTRAR'S SIGNATURE W. H. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of undertaker		11. Signature of funeral home		12. Signature of cemetery	
13. Signature of health officer		14. Signature of coroner		15. Signature of jury		16. Signature of witnesses	
17. Signature of family		18. Signature of neighbors		19. Signature of friends		20. Signature of community	
21. Signature of church		22. Signature of school		23. Signature of business		24. Signature of other	
25. Signature of other		26. Signature of other		27. Signature of other		28. Signature of other	
29. Signature of other		30. Signature of other		31. Signature of other		32. Signature of other	
33. Signature of other		34. Signature of other		35. Signature of other		36. Signature of other	
37. Signature of other		38. Signature of other		39. Signature of other		40. Signature of other	
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45. Signature of other		46. Signature of other		47. Signature of other		48. Signature of other	
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53. Signature of other		54. Signature of other		55. Signature of other		56. Signature of other	
57. Signature of other		58. Signature of other		59. Signature of other		60. Signature of other	
61. Signature of other		62. Signature of other		63. Signature of other		64. Signature of other	
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69. Signature of other		70. Signature of other		71. Signature of other		72. Signature of other	
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77. Signature of other		78. Signature of other		79. Signature of other		80. Signature of other	
81. Signature of other		82. Signature of other		83. Signature of other		84. Signature of other	
85. Signature of other		86. Signature of other		87. Signature of other		88. Signature of other	
89. Signature of other		90. Signature of other		91. Signature of other		92. Signature of other	
93. Signature of other		94. Signature of other		95. Signature of other		96. Signature of other	
97. Signature of other		98. Signature of other		99. Signature of other		100. Signature of other	

BUREAU V. S.

MAR 14 1958

RECEIVED

3519

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 2 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Leroy Middle R. Last Duerre		4. DATE OF DEATH Month March Day 11 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/9/92
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired CONDUCTOR		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Rudolph Duerre		14. MOTHER'S MAIDEN NAME Ellen Kreager	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. YES	
17. INFORMANT AMELIA DUECKE Address WHEATON, MD		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis DUE TO (c) none PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Wheaton, Md.		(County) (State)	
21. I certify that I attended the deceased from Mar. 11, 1958 , to Mar. 11, 1958 , that I lost sow the deceased olive on Mar. 11, 1958 , and that death occurred at 12:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Philip H. Varner		DATE SIGNED 3/11/58	
PHYSICIAN'S NAME (Type) Philip H. Varner		ADDRESS (Street, city or town, state) 19620 Ga. ave., Wheaton, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-15-1958	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem		22d. LOCATION (City, town, or county) (State) Bladensburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co.		24a. REC'D BY REGISTRAR 517-11 St. S.E.	
24b. REGISTRAR'S SIGNATURE W. W. Chambers Co.		DATE MAR 13 '58	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNITED STATES DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

BUREAU V. S.

MAR 18 1938

RECEIVED

#1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3520 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03483

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b 1 hr.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Franklin & Conn. Aves.		e. STREET ADDRESS 408 Boyd Ave	
3. NAME OF DECEASED (Type or print) Hiram Lester Durepo		4. DATE OF DEATH Mar. 17, 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 27, 1898
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer		10b. KIND OF BUSINESS OR INDUSTRY Building	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Charles Durepo		14. MOTHER'S MAIDEN NAME Clara Paul	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Joan Y. Dunn, 7920 18th Ave. W. Hyattsville		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. (c)			INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED Mar. 17, 1958	
EXAMINER'S NAME (Type) Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Transit Buried, Mar. 19, 1958		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Springfield Friends Cemetery		22d. LOCATION (City, town, or county) (State) Guilford County, North Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walter, 254 Carroll St NW, D.C.		24. REC'D BY REGISTRAR MAR 18 '58	
24b. REGISTRAR'S SIGNATURE W. J. Louch			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

MAR 18 1959

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3521

CERTIFICATE OF DEATH

Reg. Dist. No.

03484
215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Victoria Middle Anne Last ECHELBERGER		4. DATE OF DEATH Month March Day 2 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 29 December 1940
9. AGE (In years last birthday) 17 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Maurice Anderson Spalding		14. MOTHER'S MAIDEN NAME Ester Victoria Morgan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT (Husband) Lowell G. Echelberger (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, Lobular, Bilateral DUE TO Septicemia, generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pyelonephritis, acute, right DUE TO (c) Pyelonephritis, acute, right			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 28 February, 1958 , to 2 March , 19 58 that I last saw the deceased alive on 2 March , 19 58 , and that death occurred at 10:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Chelvin Rotun M.D. U.S. Naval Hospital, Bethesda, Md. 3-3-58			
PHYSICIAN'S NAME (Type) M. ROTNER LT MC USN U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-6-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Gartner Funeral Home, Gaithersburg, Md.		24a. REC'D BY REGISTRAR DATE MAR 7 '58	
24b. REGISTRAR'S SIGNATURE W. J. ...			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		OCCUPATION		EDUCATION	
RELIGION		MARITAL STATUS		DATE OF BIRTH	
PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH	
CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH	
MINUTE OF DEATH		SECOND OF DEATH		THIRD OF DEATH	
FOURTH OF DEATH		FIFTH OF DEATH		SIXTH OF DEATH	
SEVENTH OF DEATH		EIGHTH OF DEATH		NINTH OF DEATH	
TENTH OF DEATH		ELEVENTH OF DEATH		TWELFTH OF DEATH	
THIRTEENTH OF DEATH		FOURTEENTH OF DEATH		FIFTEENTH OF DEATH	
SIXTEENTH OF DEATH		SEVENTEENTH OF DEATH		EIGHTEENTH OF DEATH	
NINETEENTH OF DEATH		TWENTIETH OF DEATH		TWENTY-FIRST OF DEATH	
TWENTY-SECOND OF DEATH		TWENTY-THIRD OF DEATH		TWENTY-FOURTH OF DEATH	
TWENTY-FIFTH OF DEATH		TWENTY-SIXTH OF DEATH		TWENTY-SEVENTH OF DEATH	
TWENTY-EIGHTH OF DEATH		TWENTY-NINTH OF DEATH		THIRTIETH OF DEATH	
THIRTY-FIRST OF DEATH		THIRTY-SECOND OF DEATH		THIRTY-THIRD OF DEATH	
THIRTY-FOURTH OF DEATH		THIRTY-FIFTH OF DEATH		THIRTY-SIXTH OF DEATH	
THIRTY-SEVENTH OF DEATH		THIRTY-EIGHTH OF DEATH		THIRTY-NINTH OF DEATH	
FORTIETH OF DEATH		FORTY-FIRST OF DEATH		FORTY-SECOND OF DEATH	
FORTY-THIRD OF DEATH		FORTY-FOURTH OF DEATH		FORTY-FIFTH OF DEATH	
FORTY-SIXTH OF DEATH		FORTY-SEVENTH OF DEATH		FORTY-EIGHTH OF DEATH	
FORTY-NINTH OF DEATH		FIFTIETH OF DEATH		FIFTY-FIRST OF DEATH	
FIFTY-SECOND OF DEATH		FIFTY-THIRD OF DEATH		FIFTY-FOURTH OF DEATH	
FIFTY-FIFTH OF DEATH		FIFTY-SIXTH OF DEATH		FIFTY-SEVENTH OF DEATH	
FIFTY-EIGHTH OF DEATH		FIFTY-NINTH OF DEATH		SIXTIETH OF DEATH	
SIXTY-FIRST OF DEATH		SIXTY-SECOND OF DEATH		SIXTY-THIRD OF DEATH	
SIXTY-FOURTH OF DEATH		SIXTY-FIFTH OF DEATH		SIXTY-SIXTH OF DEATH	
SIXTY-SEVENTH OF DEATH		SIXTY-EIGHTH OF DEATH		SIXTY-NINTH OF DEATH	
SEVENTIETH OF DEATH		SEVENTY-FIRST OF DEATH		SEVENTY-SECOND OF DEATH	
SEVENTY-THIRD OF DEATH		SEVENTY-FOURTH OF DEATH		SEVENTY-FIFTH OF DEATH	
SEVENTY-SIXTH OF DEATH		SEVENTY-SEVENTH OF DEATH		SEVENTY-EIGHTH OF DEATH	
SEVENTY-NINTH OF DEATH		EIGHTIETH OF DEATH		EIGHTY-FIRST OF DEATH	
EIGHTY-SECOND OF DEATH		EIGHTY-THIRD OF DEATH		EIGHTY-FOURTH OF DEATH	
EIGHTY-FIFTH OF DEATH		EIGHTY-SIXTH OF DEATH		EIGHTY-SEVENTH OF DEATH	
EIGHTY-EIGHTH OF DEATH		EIGHTY-NINTH OF DEATH		NINETYETH OF DEATH	
NINETY-FIRST OF DEATH		NINETY-SECOND OF DEATH		NINETY-THIRD OF DEATH	
NINETY-FOURTH OF DEATH		NINETY-FIFTH OF DEATH		NINETY-SIXTH OF DEATH	
NINETY-SEVENTH OF DEATH		NINETY-EIGHTH OF DEATH		HUNDRETH OF DEATH	

BUREAU V. S.

MAR 7 1908

RECEIVED

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03485

3522

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ASHTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ASHTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. # 29		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle ELIZABETH Last ERVIN		4. DATE OF DEATH Month MARCH Day 30 Year 19 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/25/76
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Thompson		14. MOTHER'S MAIDEN NAME Amanda Flook	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. Wm. E. Ervin, Rt. #29, Aston, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Broncho-Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hemiplegia DUE TO (c) arterio-sclerosis.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491 X			
INTERVAL BETWEEN ONSET AND DEATH 8 days 6/7342 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/1 , 1950, to 3/30 , 1958, that I last saw the deceased alive on 3/24 , 1958, and that death occurred at 12:00A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE J. W. BIRD		ADDRESS (Street, city or town, state) DATE SIGNED Sandy Spring Md	
PHYSICIAN'S NAME (Type) J. W. BIRD		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4/1/58	22c. NAME OF CEMETERY OR CREMATORY WOODSIDE CEMETERY	22d. LOCATION (City, town, or county) (State) BRINKLOW, MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR WAR 3 1 '58		24b. REGISTRAR'S SIGNATURE W. E. Humphrey	

1. *Alnus*
 2. *Fraxinus*
 3. *Quercus*
 4. *Castanea*
 5. *Ulmus*
 6. *Salix*
 7. *Populus*
 8. *Betula*
 9. *Prunus*
 10. *Corylus*
 11. *Amygdalus*
 12. *Ligustrum*
 13. *Spiraea*
 14. *Malus*
 15. *Pyrus*
 16. *Malva*
 17. *Rosa*
 18. *Crataegus*
 19. *Opuntia*
 20. *Cercocarpus*
 21. *Adiantum*
 22. *Polypodium*
 23. *Asplenium*
 24. *Marattia*
 25. *Psidium*
 26. *Eugenia*
 27. *Myrica*
 28. *Spartina*
 29. *Phragmites*
 30. *Cyperus*
 31. *Eleocharis*
 32. *Scirpus*
 33. *Distichlis*
 34. *Panicum*
 35. *Setaria*
 36. *Tripsacum*
 37. *Verbena*
 38. *Salvia*
 39. *Origanum*
 40. *Thymus*
 41. *Phlomis*
 42. *Helianthus*
 43. *Xanthoxylum*
 44. *Albizia*
 45. *Acacia*
 46. *Prosopis*
 47. *Leucaena*
 48. *Calliandra*
 49. *Albizia*
 50. *Acacia*
 51. *Prosopis*
 52. *Leucaena*
 53. *Calliandra*
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 82. *Leucaena*
 83. *Calliandra*
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 85. *Acacia*
 86. *Prosopis*
 87. *Leucaena*
 88. *Calliandra*
 89. *Albizia*
 90. *Acacia*
 91. *Prosopis*
 92. *Leucaena*
 93. *Calliandra*
 94. *Albizia*
 95. *Acacia*
 96. *Prosopis*
 97. *Leucaena*
 98. *Calliandra*
 99. *Albizia*
 100. *Acacia*

BUREAU V.

MAR 31 1958

RECEIVED

3523

CERTIFICATE OF DEATH

Reg. Dist. No.

03486

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MOD ORKNEY PKY.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>7104 ORKNEY PKY.</u>	
3. NAME OF DECEASED (Type or print) <u>SARAH</u> First <u>B.</u> Middle <u>ESSELSTYN</u> Last		4. DATE OF DEATH <u>MARCH 11</u> Month <u>11</u> Day <u>1958</u> Year	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 10 1874</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>New York City</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Caldwell BLAKEMAN</u>		14. MOTHER'S MAIDEN NAME <u>SARAH Vosburg</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Everett J. Esselstyn</u> Address <u>I.R.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Atherosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>3 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>10:15</u> <u>MAR 11</u> <u>1958</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN 19</u> 1957, to <u>MARCH 11</u> 1958, that I last saw the deceased alive on <u>March 10</u> 1958, and that death occurred at <u>10:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wesley M. Oler</u>		DATE SIGNED <u>M.D. 1150 Conn. Av. N.W. Wash. D.C. 3-11-58</u>	
PHYSICIAN'S NAME (Type) <u>WESLEY M. OLER M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATE</u>	22b. DATE THEREOF <u>3-12-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lee CREMATORY</u>	22d. LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. M. Jones</u> ADDRESS <u>300 - 4 ST N.E.</u>		24a. REC'D BY REGISTRAR <u>MAR 12 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. C. Oler</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1959

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

BUREAU V. S.

MAR 12 1959

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

3521

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>93 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hills</u> 69x-3 ✓		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>7159 Kessel Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emilio</u> Middle <u>(none)</u> Last <u>Falcocchio</u>				4. DATE OF DEATH Month <u>March</u> Day <u>15</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>19 July 1912</u>	
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>Italy</u> ✓	
13. FATHER'S NAME <u>Paolo Falcocchio</u>				14. MOTHER'S MAIDEN NAME <u>Maria Ranaletta</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>The Medical Record Address</u> <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho Pneumonia, L. L.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Hamman-Rich Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cor pulmonale</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>6 yr.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December 12, 1957</u> , to <u>March 15, 1958</u> , that I last saw the deceased alive on <u>March 15, 1958</u> , and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Richard Crout</u>				ADDRESS (Street, city or town, state) <u>The Clinical Center</u>		DATE SIGNED <u>3/15/58</u>	
PHYSICIAN'S NAME (Type) <u>J. Richard Crout, M. D.</u>				National Institutes of Health <u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>SHIP. RR.</u>		22b. DATE THEREOF <u>3-15-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FOREST HILLS NEW YORK</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers G</u>				ADDRESS <u>1400 Chapin St NW</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 18 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. W. Chambers</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

UNRECORDED

BUREAU V. 8

MAR 18 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03488

3525

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington, D. C. b. COUNTY 47x-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 8 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edith Middle Marie Last Fenton		4. DATE OF DEATH Month March Day 22 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/21/86
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 71	IF UNDER 24 HRS. Days 71 Hours 71 Min. 71
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Gustaf A. Olson		14. MOTHER'S MAIDEN NAME Marie C. Homberg	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Irene W. Olson Chicago 17, Illinois		8006 Oglesby Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1810 DUE TO Transition Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) Adenocarcinoma of Bladder DUE TO (c) 12 year		INTERVAL BETWEEN ONSET AND DEATH 3 mo 6 mo 12 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/26, 1957 to 3/22, 1958 , that I last saw the deceased alive on 3/21, 1958 , and that death occurred at 6:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sandy Spring, Maryland DATE SIGNED 3/22/58			
ACTUAL SIGNATURE C. H. Ligon		M.D. Sandy Spring, Maryland	
PHYSICIAN'S NAME (Type) C. H. Ligon, M.D.		Sandy Spring, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF MAR 24, 1958	
22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		22d. LOCATION (City, town, or county) (State) PENNSYLVANIA (EXT.) PA 80, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters, 254 Carroll St NW DC		24. RECORD BY REGISTRAR MAR 26 1958	
24b. REGISTRAR'S SIGNATURE Arthur Walters		24c. REGISTRAR'S SIGNATURE Arthur Walters	

[illegible]

MAR 26 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3526

CERTIFICATE OF DEATH

03489

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 37 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kentucky b. COUNTY Redcliff c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55X-3 d. STREET ADDRESS Route 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Barbara Ann Fetterman				4. DATE OF DEATH Month Day Year March 11, 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 25, 1938	
9. AGE (In years last birthday) 19 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Earl M. Graham				14. MOTHER'S MAIDEN NAME Mary A. Reese			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 202-30-0525		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause on line for a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO of - Refrain Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cordine Fibrillation DUE TO (c) Rheumatic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatic Heart Disease INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 2, 1958 to March 11, 1958 , that I last saw the deceased alive on March 11, 1958 , and that death occurred at 8:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 3/12/58 The National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Transit		22b. DATE THEREOF 3/13/58		22c. NAME OF CEMETERY OR CREMATORY Bellwood, Pennsylvania		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE MAR 17 '58		24b. REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MAINE STATE DEPARTMENT OF HEALTH - BANGOR

BUREAU V. E.

MAR 17 1958

RECEIVED

Robert A. Ramsey-Roberts, M.D.

3/17/58

Bellwood

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. S.

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

3528 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03491

Items 13 & 14, File G228, 4/21/58 10y

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville, R.F.D.		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rockville, R. F. D.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bond Rd. nr Norbeck			d. STREET ADDRESS Bond Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) John Henry Gaines			4. DATE OF DEATH Mar. 20, 1958		
5. SEX male	6. COLOR OR RACE col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/24/ 1907		9. AGE (In years last birthday) 50 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S.C.	
13. FATHER'S NAME West Gaines			14. MOTHER'S MAIDEN NAME Lizzie Warren		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 251-46-0205		17. INFORMANT Montg. Co. Police	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 434.1 IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO Exposure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Found dead in woods					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was enroute home thru snow storm when he collapsed			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year ____ 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Mar. 21, 1958	
22a. BURIAL, CREMATION, or other disposal (Specify) Burial	22b. DATE THEREOF 3/29/58	22c. NAME OF CEMETERY OR CREMATORY Ash Memorial,		22d. LOCATION (City, town, or county) _____ (State) _____ Sandy Spring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Surden			ADDRESS Rockville, Md.		24c. REC'D BY REGISTRAR DATE MAR 27 '58
			24b. REGISTRAR'S SIGNATURE W. L. Smith		

BUREAU V. 3

MAR 07 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3529

CERTIFICATE OF DEATH

03492

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE NORTH CAROLINA b. COUNTY DURHAM	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA (RURAL)		c. LENGTH OF STAY IN 1b 11 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. NAVAL HOSPITAL BETHESDA, MD.		d. STREET ADDRESS 2513 HART ST.	
3. NAME OF DECEASED (Type or print) First Middle Last DONALD HOWARD GEER		4. DATE OF DEATH Month Day Year MARCH 29 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 FEBRUARY 1935
9. AGE (In years last birthday) 23 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. NAVY		10b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY	
11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME DONALD MAURICE GEER		14. MOTHER'S MAIDEN NAME NELLIE EVA CAMPBELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 4/15/52-3/25/58	
17. INFORMANT (WIFE) SHIRLEY JEAN GEER (SAME AS # 2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 593X IMMEDIATE CAUSE (a) GLOMERULONEPHRITIS WITH PULMONARY EDEMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 18 MARCH , 19 58 , to 29 MARCH , 19 58 , that I last saw the deceased alive on 29 MARCH , 19 58 , and that death occurred at 2:35 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE R.G. Galbraith		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) R.G. GALBRAITH LT MC USN		U.S. NAVAL HOSPITAL BETHESDA, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-1-58	
22c. NAME OF CEMETERY OR CREMATORY WOODLAWN MEMORIAL PARK		22d. LOCATION (City, town, or county) (State) DURHAM, NORTH CAROLINA	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS CO. 1400 CHAPIN ST. N.W.		24a. REC'D BY REGISTRAR APR 7 58	
24b. REGISTRAR'S SIGNATURE			

APR 7 1958

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JUL 7 1958

Reg. Dist. No. 03493

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia		b. COUNTY Alexandria	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria Kensington		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria		83X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Nursing Home				d. STREET ADDRESS 3000 McComas Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDWIN Thomas		First Hayden		Middle Gibbs		Last	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH Month 3 Day 17 Year 1958	
8. DATE OF BIRTH April 3 1873		9. AGE (In years last birthday) 74		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Thomas Hayden Gibbs		14. MOTHER'S MAIDEN NAME Helen Ashby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 577-03-7010A		17. INFORMANT Mrs. Frances Prowse		Address Alexandria, Va. 2501 Crest St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Cremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Arteriosclerotic cardiovascular disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 months 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-16-58 to 3-17-58 that I last saw the deceased alive on 3-11-58 , and that death occurred at 6:25 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE C. Roger Kurtz		M.D. 3701 Connecticut Ave. NW		ADDRESS (Street, city or town, state) Washington 8, D.C.		DATE SIGNED 3-17-58	
PHYSICIAN'S NAME (Type) C. Roger Kurtz M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/20/58		22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Washington DC	
23. FUNERAL DIRECTOR'S SIGNATURE 1756 Pa. Ave. NW Wash. DC				24a. REC'D BY REGISTRAR DATE MAR 19 1958		24b. REGISTRAR'S SIGNATURE W. H. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VS A15 (4)
15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3531

CERTIFICATE OF DEATH

Reg. Dist. 23494

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 20 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gary Middle Guy Last Gienger		4. DATE OF DEATH Month March Day 25 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 20, 1941
9. AGE (In years last birthday) 16 yrs.		10. IF UNDER 1 YEAR Months 16 Days 16 Hours 16 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Guy Gienger		14. MOTHER'S MAIDEN NAME Anna Maie Edmunds	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mossame Cerebral Hemorrhage DUE TO Acute Myelogenous Leukemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 18 hours (c) 1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 5, 1958 , to March 25, 1958 , that I last saw the deceased alive on March 25, 1958 , and that death occurred at 4:50 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dane R. Boggs		ADDRESS (Street, city or town, state) The Clinical Center	
PHYSICIAN'S NAME (Type) Dane R. Boggs, M. D.		DATE SIGNED 3/26/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/28/58	
22c. NAME OF CEMETERY OR INTERMENT George Washington		22d. LOCATION (City, town, or county) (State) Hyattsville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR DATE MAR 31 '58		24b. REGISTRAR'S SIGNATURE W. L. Gough	

MAR 31 1958

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3532

CERTIFICATE OF DEATH

Reg. Dist. No. 83495

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 9 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4617 S. Chelsea Lane		d. STREET ADDRESS 4617 S. Chelsea Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GRACE Middle M. Last GIESEKING		4. DATE OF DEATH Month March Day 2 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 9, 1873
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME John A. Miller		14. MOTHER'S MAIDEN NAME Elizabeth Addison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT Miller W. Gieseeking Address Item # 2
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Arteriosclerotic Heart Disease (c) 10 YR PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 12 hrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan , 19 53 , to March , 19 58 , that I last saw the deceased alive on March , 19 58 , and that death occurred at 3P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 8016 Old Georgetown Rd. 3-2-58			
ACTUAL SIGNATURE Leo I. Donovan M.D.		PHYSICIAN'S NAME (Type) LEO I. DONOVAN Bethesda, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/5/58	22c. NAME OF CEMETERY OR CREMATORY Oak Hill	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland		24a. REC'D BY REGISTRAR MAR 5 '58	24b. REGISTRAR'S SIGNATURE W. H. Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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3533 CERTIFICATE OF DEATH

Reg. Dist. No. 3495

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>12 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Luther</u> Middle <u>H</u> Last <u>Gladwell</u>		4. DATE OF DEATH Month <u>March</u> Day <u>21</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/11/75</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Izar Gladwell</u>		14. MOTHER'S MAIDEN NAME <u>Amida Gladwell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>069-22-3648</u>	
17. INFORMANT <u>Mrs. Della Dodson, Granddaughter,</u> Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>420.0</u> DUE TO <u>Arterio-Sclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> <u>hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/21</u> , 19 <u>58</u> , to <u> </u> , 19 <u> </u> , that I last saw the deceased alive on <u>3/21</u> , 19 <u>58</u> , and that death occurred at <u>7:55 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Sandy Spring, Maryland</u> DATE SIGNED <u>3/24/58</u>			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u> </u>			
PHYSICIAN'S NAME (Type) <u>C. H. Ligon, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 24, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u> ADDRESS <u>254 Carroll Dr NW DC</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>MAR 24 58</u>	
		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

5233

51

PLACE TO BE FILLED BY THE REGISTRAR		PLACE TO BE FILLED BY THE DEATH INVESTIGATOR	
NAME OF DECEASED		NAME OF DEATH INVESTIGATOR	
RESIDENCE OF DECEASED		RESIDENCE OF DEATH INVESTIGATOR	
DATE OF DEATH		DATE OF DEATH	
PLACE OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MANNER OF DEATH	
AGE OF DECEASED		AGE OF DEATH INVESTIGATOR	
SEX OF DECEASED		SEX OF DEATH INVESTIGATOR	
RACE OF DECEASED		RACE OF DEATH INVESTIGATOR	
RELIGION OF DECEASED		RELIGION OF DEATH INVESTIGATOR	
EDUCATION OF DECEASED		EDUCATION OF DEATH INVESTIGATOR	
OCCUPATION OF DECEASED		OCCUPATION OF DEATH INVESTIGATOR	
MARRIAGE OF DECEASED		MARRIAGE OF DEATH INVESTIGATOR	
SINGLE		SINGLE	
MARRIED		MARRIED	
DIVORCED		DIVORCED	
WIDOWED		WIDOWED	
SIGNATURE OF REGISTRAR		SIGNATURE OF DEATH INVESTIGATOR	
DATE		DATE	
PLACE		PLACE	
COUNTY		COUNTY	
STATE		STATE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3462

CERTIFICATE OF DEATH

Reg. Dist. No. 3497

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park 17</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>8510 Greenwood Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Dorothy Mae Goodman</u> First Middle Last				4. DATE OF DEATH <u>March 6 1958</u> Month Day Year			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-4-10</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Aswp.</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Frank Petty</u>				14. MOTHER'S MAIDEN NAME <u>Mary G. Hartman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> [If yes, give war or dates of service]				16. SOCIAL SECURITY NO.		17. INFORMANT <u>George S. Goodman</u> Address <u>Takoma Park, Md. 8510 Greenwood Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260x Congestive Heart failure</u> DUE TO (b) <u>Diabetes mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/5/58</u> , 19 <u>58</u> , to <u>3/6/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/6/58</u> , 19 <u>58</u> , and that death occurred at <u>12:45</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas H. Wolohin</u> M.D.				ADDRESS (Street, city or town, state) <u>Washington D.C.</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Chas H. Wolohin</u>				<u>300 Underwood, St NW</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR. 10, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>		22d. LOCATION (City, town, or county) (State) <u>WHEATON. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Taltavull</u> ADDRESS <u>3603 14th St NW</u>				24a. REC'D BY REGISTRAR <u>W. W. Taltavull</u> DATE <u>MAR 10 1958</u>		24b. REGISTRAR'S SIGNATURE <u>W. W. Taltavull</u>	

CERTIFICATE OF DEATH

1. PLACE OF DEATH
2. DATE OF DEATH
3. TIME OF DEATH
4. SEX
5. AGE
6. RACE
7. OCCUPATION
8. MARITAL STATUS
9. CAUSE OF DEATH
10. PLACE OF BIRTH
11. DATE OF BIRTH
12. SIGNATURE OF REGISTRAR
13. SIGNATURE OF WITNESS
14. SIGNATURE OF DECEASED

BUREAU V. S.

MAR 10 1958

RECEIVED

CERTIFICATE OF DEATH

03498

Reg. Dist. No.

3534

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 67 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Champaign 51X-3	
f. STREET ADDRESS 1610 Sangamon Drive		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Karl Eitel Goodman		4. DATE OF DEATH Month Day Year March 10 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1913
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contract Specialist		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Ernst Goodman		14. MOTHER'S MAIDEN NAME Mina Gunzberger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 334-18-4646	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Acute Lymphocytic Leukemia DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 2, 1958 , to March 10, 1958 , that I last saw the deceased alive on March 10, 1958 , and that death occurred at 6:00 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Roger Lester		ADDRESS (Street, city or town, state) The Clinical Center The National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) Roger Lester, M.D.		DATE SIGNED 3/10/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Transit		22b. DATE THEREOF 3/10/58	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Chicago, Illinois	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR DA 11 12 '58	
24b. REGISTRAR'S SIGNATURE Paul...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, occupation, cause of death, and place of death. The form is mostly blank with some faint markings.

RECEIVED
MAR 12 1958
BUREAU X. F.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3555

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03499

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>5 mo</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4740 Bradley Blvd</u>		d. STREET ADDRESS <u>4740 Bradley Blvd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Joseph Godwin Greenfield</u>		4. DATE OF DEATH <u>March 2 1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-24-'84</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>neuropathologist</u>	
11. BIRTHPLACE (State or foreign country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. Britain</u>	
13. FATHER'S NAME <u>Wm Smith Greenfield</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte Foster</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Florence Mary Greenfield (wife)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary atherosclerosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>3-2-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>3/3/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>W. S. S. S.</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>W. S. S. S.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH



BUREAU V. S.

MAR 5 1958

RECEIVED

Robert A. Campbell, M.D.
Cecil Hill
3/11/58

3536

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY ALEXANDRIA VIRGINIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. NAVAL HOSPITAL, BETHESDA, MD.		d. STREET ADDRESS 1210 JANNEYS LANE	
3. NAME OF DECEASED (Type or print) SYDNE First ARTHUR Middle GREENLEAF Last		4. DATE OF DEATH Month 3 Day 22 Year 19 58	
5. SEX M	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-10-1878
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. NAVAL OFFICER		10b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY	
11. BIRTHPLACE (State or foreign country) NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME ENOCH GREENLEAF		14. MOTHER'S MAIDEN NAME AMINE PERRY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO.	
17. INFORMANT ALEXANDRIA VA. LUCY W. GREENLEAF 1210 JANNEYS LANE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 27 February, 19 58 , to 22 March 19 58 , that I last saw the deceased alive on 22 March , 19 58 , and that death occurred at 7:17A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 3-22-58			
ACTUAL SIGNATURE R.G. Galbraith Jr		M.D. U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) R.G. Galbraith, Jr. LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-25-58	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON, NATIONAL		22d. LOCATION (City, town, or county) (State) ARLINGTON VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE CUNNINGHAM		ADDRESS CAMERON AND ALFRED ST ALEXANDRIA VIRGINIA	
24a. REC'D BY REGISTRAR MAR 26 58		24b. REGISTRAR'S SIGNATURE W. H. H. H.	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED

AGE

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RACE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF CEMETERY

NAME OF BURIAL

NAME OF CREMATION

NAME OF OTHER

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF CEMETERY

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BUREAU V. 8

MAR 26 1958

RECEIVED

3537

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>905 22nd Street, N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle <u>H</u> Last <u>Greenstreet</u>		4. DATE OF DEATH Month <u>March</u> Day <u>5</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 16, 1874</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>	
11. BIRTHPLACE (State or foreign country) <u>REXBURG, Essex County Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>WILLIAM FRANCIS Greenstreet</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Lewis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>577-09-7301</u>	
17. INFORMANT <u>Benjamin Greenstreet</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis - Nephritis.</u> DUE TO (c) <u>Hypertension</u> 10 yrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19 40</u> to <u>March 5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 4</u> , 19 <u>58</u> , and that death occurred at <u>4 40</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2140 Pa. Ave. N.W.</u> DATE SIGNED			
ACTUAL SIGNATURE <u>Paul N. Taylor</u>		M.D. <u>PAUL N. TAYLOR M.D.</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/7/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph F. Becker</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 7 58</u>	
ADDRESS <u>3034 M St NW</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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BUREAU V. S.

MAR 7 1958

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03502

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8201 Old Georgetown Road		d. STREET ADDRESS 8201 Old Georgetown Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle RICHARD Last GRIEST		4. DATE OF DEATH Month March Day 23 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 19, 1900
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 7 Days 4	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Eng.		10b. KIND OF BUSINESS OR INDUSTRY Vet. Adm.	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Charles A Griest		14. MOTHER'S MAIDEN NAME Caroline Staley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) WW 11		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miriam G Griest-Item# 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertension (a), stating the underlying cause last. DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH sudden years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) History of previous heart attacks			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 3/23/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/26/58	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Suitland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE MAR 26 '58		24b. REGISTRAR'S SIGNATURE 	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex	
John Doe		35		Male	
Residence		Occupation		Cause of Death	
123 Main St, Baltimore, Md		Teacher		Heart Disease	
Date of Death		Time of Death		Place of Death	
April 15, 1958		10:30 AM		Home	
Medical History		Family History		Previous Illnesses	
Hypertension		None		None	
Treatment		Autopsy		Disposition	
None		Yes		Buried	
Burial Place		Funeral Home		Remarks	
St. Mary's Cemetery		Doe & Sons		None	

RECEIVED
MAR 26 1958
BUREAU V. R.

CERTIFICATE OF DEATH

Reg. Dist. No.

03503

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 10 minutes d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Hospital & Sanitarium		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring, Maryland d. STREET ADDRESS 527-DALE DRIVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Fannie First (NMN) Middle GUDE Last		4. DATE OF DEATH Month MARCH Day 11 Year 1958	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1886 Oct 4, 1886
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR: Months 11 Days 11 Hours 19 Min. 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HWSE		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William E. Thompson		14. MOTHER'S MAIDEN NAME Elizabeth Shaw	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT Bessie L. Hollis - 203 Peabody St N.W.		Address Wash D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute subarachnoid hemorrhage 330X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) —			INTERVAL BETWEEN ONSET AND DEATH 10 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 1, 1958 , to March 11, 1958 , that I last saw the deceased alive on March 11, 1958 , and that death occurred at 1:00 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Bennet A. Porter, Jr., M.D.		ADDRESS (Street, city or town, state) 9301 Colesville Rd, Silver Spring, Md.	
DATE SIGNED March 11, 1958			
PHYSICIAN'S NAME (Type) BENNET A. PORTER JR., M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3/14/58	22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE W. E. Humphrey		ADDRESS 8434 Ya Ave N	
24a. REC'D BY REGISTRAR MAR 12 '58		24b. REGISTRAR'S SIGNATURE Overseer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. DATE OF DEATH		7. PLACE OF BIRTH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF FUNERAL HOME		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF CORONER		16. SIGNATURE OF JURY		17. SIGNATURE OF JUDGE		18. SIGNATURE OF CLERK		19. SIGNATURE OF NOTARY		20. SIGNATURE OF OTHER OFFICIALS	

RECEIVED
 MAR 12 1959
 BUREAU V. 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3539

CERTIFICATE OF DEATH

Reg. Dist. No. **03504**

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN Hospital		d. STREET ADDRESS ROUTE #1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BABY Middle BOY Last HAMMOND		4. DATE OF DEATH Month MARCH Day 23 Year 1958	
5. SEX MALE	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 22nd 1958
9. AGE (In years last birthday) yrs. 40		IF UNDER 1 YEAR Months 40 Days 40 Hours 40 Min. 40	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME NOT GIVEN		14. MOTHER'S MAIDEN NAME LUCILLE VIRGINIA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. —	
17. INFORMANT MOTHER		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory insufficiency DUE TO 762.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bilateral pneumothorax DUE TO 40 min (c) Ruptured pleural blebs 40 min		INTERVAL BETWEEN ONSET AND DEATH 40 min 40 min 40 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from march 22nd 1958 , to march 23 1958 , that I last saw the deceased alive on march 23rd 1958 , and that death occurred at 130A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE James S. Stanton M.D.			
PHYSICIAN'S NAME (Type) Dr James S. Stanton 809 Viers Mill Rd. Rockville Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremated		22b. DATE THEREOF 5-24-58	
22c. NAME OF CEMETERY OR CREMATORY Suburban Hosp. Bethesda, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE William M. Carter, Sept.		ADDRESS	
24a. REC'D BY REGISTRAR DATE 10-7-58		24b. REGISTRAR'S SIGNATURE Ans...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2074171XV0

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. 3

APR 7 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03505

3464

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium</u>				d. STREET ADDRESS <u>5607 Chillum Hts Dr.</u>			
3. NAME OF DECEASED (Type or print) First <u>Dianne</u> Middle <u>Elizabeth</u> Last <u>Harrington</u>				4. DATE OF DEATH Month <u>2</u> Day <u>22</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>2-23-58</u>		9. AGE (In years last birthday) <u>1</u>	
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>	
						IF UNDER 24 HRS. Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, DC.</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>Yes</u>	
13. FATHER'S NAME <u>Richard J. Harrington</u>				14. MOTHER'S MAIDEN NAME <u>Katharina Englert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Father</u>	
						Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>470x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Upper Respiratory Infection</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of "cold" and cough for two days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>—</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Hour <u>—</u> o. m. <u>—</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHEAT</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/25/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. RECEIVED BY REGISTRAR <u>MAR 24 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>—</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

DEPARTMENT OF HEALTH - BALTIMORE, MD
XAMINER'S CERTIFICATE OF DEATH

BUREAU V. 37

MAR 24 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3540

CERTIFICATE OF DEATH

Reg. Dist. No. 215

035406

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington b. COUNTY D. C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 34 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.			
d. STREET ADDRESS 2755 Macomb St., N. W.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Blanche Middle Thyson Last HARRISON				4. DATE OF DEATH Month March Day 30 Year 19 58			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 1, 1880	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min. 77		IF UNDER 24 HRS. Months 77 Days 77 Hours 77 Min. 77			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Hermanus George THYSON				14. MOTHER'S MAIDEN NAME Susan DEWDNEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Paulus THYSON (Bro) Address 4405 Harrison St., Wash., DC			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extension of Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Coronary Artery Disease DUE TO (c) Generalized Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 48 hrs 10 yrs							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Feb 25 , 19 58 , to Mar 30 , 19 58 , that I last saw the deceased alive on Mar 29 , 19 58 , and that death occurred at 0:50 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Fredm S Caldwell				ADDRESS (Street, city or town, state) DATE SIGNED 3-31-58			
PHYSICIAN'S NAME (Type) F. S. CALDWELL LT MC USNR							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 2, 1958		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's & Sons				24a. REC'D BY REGISTRAR APR 3 '58		24b. REGISTRAR'S SIGNATURE Alfred	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

BUREAU V. S.

APR 3 1953

RECEIVED

3465

CERTIFICATE OF DEATH

Reg. Dist. No.

08507

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Carlyle</u> Middle <u>Boynton</u> Last <u>Haynes</u>				4. DATE OF DEATH Month <u>March</u> Day <u>11</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-24-82</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Conn.</u>				12. CITIZEN OF WHAT COUNTRY? <u>Amer. (U.S.)</u>			
13. FATHER'S NAME <u>Samuel Haynes</u>				14. MOTHER'S MAIDEN NAME <u>Loretta Bazzell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Chart</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Nephrosclerosis</u> DUE TO " (c) <u>Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u> <u>2 yrs plus</u> <u>severe yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Adrenal Cortical atrophy; Lung Abscess; Emphysema</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1957</u> 19 <u>1958</u> to <u>Mar 11</u> 19 <u>1958</u> that I last saw the deceased alive on <u>Mar 11</u> 19 <u>58</u> and that death occurred at <u>9:10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Raymond O. West</u>				DATE SIGNED <u>Mar 14 1958</u>			
PHYSICIAN'S NAME (Type) <u>RAYMOND O. WEST</u>				ADDRESS (Street, city or town, state) <u>Washington Sanitarium, Takoma Park Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 14-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Leo Oak Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>				ADDRESS <u>254 Carroll St NW LOC</u>			
24a. RECEIVED BY REGISTRAR <u>Mar 14 58</u>				24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. DISEASE OR INJURY		12. MANNER OF DEATH	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF WITNESSES		16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF BURIAL OFFICIAL	

BUREAU V. S.

MAR 14 1938

RECEIVED

Handwritten signature and notes at the bottom of the form.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G227 3-28-58 et

3541

CERTIFICATE OF DEATH

Reg. Dist. No. 03508

1. PLACE OF DEATH o. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7540 Hampden Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First KATHRYN Middle LYTLE Last HENNESSEY		4. DATE OF DEATH Month March Day 21 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 30, 1900
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 5 Days 21	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME Marxhalla Blaine Lytle	
14. MOTHER'S MAIDEN NAME Katherine Herrick		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Address Philip J Hennessey, same as 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident. 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Probable extension of hemiparesis DUE TO (c) 1 hour.			INTERVAL BETWEEN ONSET AND DEATH 1 hour.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 5:15 p. m. 3/21/58	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1948 , 19 to May 1 , 19 58 that I lost saw the deceased alive on 3/17 , 19 58 , and that death occurred at 5:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward J. Staegleitz		ADDRESS (Street, city or town, state) 1726 E. St. N.W. Washington DC	
PHYSICIAN'S NAME (Type) Edward J. Staegleitz		DATE SIGNED MAR 24 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 3/25, 58	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	22d. LOCATION (City, town, or county) (State) Suitland Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR MAR 24 1958	24b. REGISTRAR'S SIGNATURE W. S. S. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1027 HANCOCK ST. BALTIMORE, MD. 21205

DECEASED: MARY ANN HANCOCK

DATE OF DEATH: MARCH 24, 1959

PLACE OF DEATH: HOME

CAUSE OF DEATH: HEART DISEASE

DATE OF BIRTH: MARCH 24, 1900

PLACE OF BIRTH: BALTIMORE, MD.

EDUCATION: HIGH SCHOOL

OCCUPATION: HOUSEWIFE

RELIGION: METHODIST

PREVIOUS ILLNESS: NONE

DATE OF EXAMINATION: MARCH 24, 1959

DATE OF SIGNATURE: MARCH 24, 1959

SIGNATURE: [Illegible]

DATE OF SIGNATURE: MARCH 24, 1959

SIGNATURE: [Illegible]

DATE OF SIGNATURE: MARCH 24, 1959

SIGNATURE: [Illegible]

BUREAU VI S

MAR 24 1959

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3542

CERTIFICATE OF DEATH

Reg. Dist. No.

03509

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>—</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D. C. 47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resmor Sanatorium</u>				d. STREET ADDRESS <u>3020 Tilden St., N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Billingsley</u> Last <u>Hill</u>				4. DATE OF DEATH Month <u>March</u> Day <u>16</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 2, 1875</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>judge U.S. Court</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Law</u>		11. BIRTHPLACE (State or foreign country) <u>Arkansas</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>William E. Hill</u>			
14. MOTHER'S MAIDEN NAME <u>Jane Billingsley</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			
16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT <u>wife Mrs. Waver Hill</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X</u> DUE TO <u>pneumonitis (bronchopneumonia)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cerebral thrombosis</u> (c) <u>arterio sclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 week</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X acute congestive heart failure</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. <u>—</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Washington, D.C.</u>				20g. (County) <u>—</u>			
20h. (State) <u>—</u>				20i. (Country) <u>—</u>			
21. I certify that I attended the deceased from <u>Feb 15, 1958</u> to <u>March 16, 1958</u> , that I last saw the deceased alive on <u>March 16, 1958</u> , and that death occurred at <u>7:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. Fred R. Ehrmentraut</u> M.D.				ADDRESS (Street, city or town, state) <u>4890 Battery Lane Bethesda, Md.</u>			
PHYSICIAN'S NAME (Type) <u>W. Fred R. Ehrmentraut M.D.</u>				DATE SIGNED <u>3/16/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/19/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co. Washington, D. C.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 18 1958</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Hill</u>	

14
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03510

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery 3543 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase c. LENGTH OF STAY IN 1b 5 yrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3607 Chevy Chase Lake Dr.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase d. STREET ADDRESS 3607 Chevy Chase Lake Dr. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rita W. Hines First Middle Last 4. DATE OF DEATH Mar. 7, 1958 Month Day Year		5. SEX female 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH May 23, 1876 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (in years last birthday) 81 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Cal. 11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME Gen. Wm M. Wherry		14. MOTHER'S MAIDEN NAME Alice Grammer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None 17. INFORMANT Alice Cleland (daughter) Sames # 2 Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.2 IMMEDIATE CAUSE (a) Angina Pectoris DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 904.9 DUE TO (c) Fracture of left hip Sept. 1957		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 904.9		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED Mar. 7, 1958	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 3/11/58	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR Bethesda, Maryland DATE MAR 12 '58	
		24b. REGISTRAR'S SIGNATURE Quesada	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
MAR 12 1958
BUREAU V. E.

3541

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3421 Farthing Drive, Silver Spring, Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montg. County General Hospital</u>				d. STREET ADDRESS <u>3421 Farthing Drive</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <u>Cheryl</u> Middle <u>Lynn</u> Last <u>Horman</u>		4. DATE OF DEATH		Month <u>March</u> Day <u>17</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 15, 1958</u>		9. AGE (In years last birthday) yrs. <u>2</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>George Robert Horman</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Harter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>George Robert Horman, same as 2d</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Microcephalus, occipital meningococci, deformity of cervical vertebrae.</u> DUE TO (b) <u>2 days.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>none</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, <u>March</u> Day, <u>17</u> Year <u>1958</u> Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 15, 1958</u> to <u>March 17, 1958</u> , that I last saw the deceased alive on <u>March 17, 1958</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. A. Smith</u> M.D.				ADDRESS (Street, city or town, state) <u>26 N. Summit Ave.</u>		DATE SIGNED <u>3/18/58</u>	
PHYSICIAN'S NAME (Type) <u>W. A. Smith</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/19/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>MAR 20 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. A. Smith</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2073303XV2

BUREAU V. P.

MAR 20 1958

RECEIVED

3545

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs Mary G Ireland</u>				4. DATE OF DEATH Month Day Year <u>March 12 1958</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 24 1867</u>	
9. AGE (In years last birthday) <u>90</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Not Available</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. A</u>	
13. FATHER'S NAME <u>J. N. Loughborough</u>				14. MOTHER'S MAIDEN NAME <u>Not Available</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Karl Koch</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Sub arachnoid Hemorrhage</u> DUE TO <u>Generalized For advanced Arterio-sclerosis + Senility</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility</u> (c) <u>Sclerosis + Senility</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>9-13</u> , 19 <u>57</u> , to <u>12 March</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11 March</u> , 19 <u>58</u> , and that death occurred at <u>10:00 P.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)						DATE SIGNED	
ACTUAL SIGNATURE <u>John Basley Zeger M.D. Olney, Md.</u>				<u>12 March 58</u>			
PHYSICIAN'S NAME (Type) <u>JOHN B. ZEPHER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>MAR 14, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GREEN WASHINGTON EM</u>		22d. LOCATION (City, town, or county) (State) <u>Rivers Rd Pigeon Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Hall</u>				ADDRESS <u>2546 Carroll St N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 14 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Alfred</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
AGE		SEX	
RACE		OCCUPATION	
EDUCATION		MARRIAGE	
BIRTH		DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
PLACE OF DEATH		DATE OF BURIAL	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	
SIGNATURE OF JUDGE		SIGNATURE OF CLERK	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	
SIGNATURE OF JUDGE		SIGNATURE OF CLERK	

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BUREAU V. 81

MAR 14 1958

RECEIVED

For file Mar 1958
 1958 George W. Johnson & Co
 1001 2nd St
 Baltimore, Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3546

CERTIFICATE OF DEATH

03513

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc. 1239 Colesville-Beltsville Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Dianne Middle Richetta Last Jackson		4. DATE OF DEATH Month March Day 17 Year 19 58	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 11, 1958
9. AGE (In years last birthday) yrs. 6		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 6 Days 6 Hours 6 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard John Jackson		14. MOTHER'S MAIDEN NAME Margaret Anne Davenport	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Hospital Records	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 763.5 IMMEDIATE CAUSE (a) Interstitial Pneumonitis DUE TO (b) Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 day 6 days			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/11/58 , 19___, to 3/17/58 , 19___, that I last saw the deceased alive on 3/17/58 , 19___, and that death occurred at 2:57 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Richard A. Yates M.D.		ADDRESS (Street, city or town, state) Olney, Md.	
DATE SIGNED 3/18/58			
PHYSICIAN'S NAME (Type) Richard A. Yates, M.D., Olney, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/19/58	
22c. NAME OF CEMETERY OR CREMATORY Good Hope.,		22d. LOCATION (City, town, or county) (State) Colesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		ADDRESS Rockville, Md.	
24a. REC'D BY REGISTRAR MAR 21 '58		24b. REGISTRAR'S SIGNATURE Alfred Leach	

CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
PLACE OF BIRTH [REDACTED]		DATE OF BIRTH [REDACTED]		PLACE OF DEATH [REDACTED]	
OCCUPATION [REDACTED]		CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]	
DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]		PLACE OF INTERMENT [REDACTED]	
NAME OF PHYSICIAN [REDACTED]		NAME OF FUNERAL HOME [REDACTED]		NAME OF MINISTER [REDACTED]	
NAME OF NEXT OF KIN [REDACTED]		NAME OF WITNESS [REDACTED]		NAME OF REGISTRAR [REDACTED]	
SIGNATURE OF PHYSICIAN [REDACTED]		SIGNATURE OF FUNERAL HOME [REDACTED]		SIGNATURE OF MINISTER [REDACTED]	
SIGNATURE OF NEXT OF KIN [REDACTED]		SIGNATURE OF WITNESS [REDACTED]		SIGNATURE OF REGISTRAR [REDACTED]	

BUREAU V. E.

MAR 21 1958

RECEIVED

3547

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
c. LENGTH OF STAY IN b. 50 yrs.		d. STREET ADDRESS Jackson Rd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elisabeth Middle Bennett Last Jackson		4. DATE OF DEATH Month March Day 28 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 5, 1878
9. AGE (In years last birthday) 79		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Spencerville, Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George H. Bennett	
14. MOTHER'S MAIDEN NAME Emma Mause		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT James O. Williams, 4904 Glen Cove Pkwy., Bethesda Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery thrombosis - myocardial infarction DUE TO Generalized arteriosclerotic cerebrovascular disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 7 yrs. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1949 , to Mar 1958 , that I last saw the deceased alive on 28 Mar 1958 , and that death occurred at 9:45 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9301 Colesville Rd Silver Spring Md. DATE SIGNED 28 Mar 1958			
ACTUAL SIGNATURE Ernest E Harmon M.D.		PHYSICIAN'S NAME (Type) Ernest E Harmon M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 1, 1958	22c. NAME OF CEMETERY OR CREMATORY Colesville Cemetery	22d. LOCATION (City, town, or county) (State) Colesville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		24a. REC'D BY REGISTRAR DATE MAR 31 '58	24b. REGISTRAR'S SIGNATURE Alfred Smith

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 would be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03515

Reg. Dist. No.

3548

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>monty</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>2 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4400 Garrett Pk. Rd.</u>			d. STREET ADDRESS <u>4400 Garrett Pk. Rd.</u>		
3. NAME OF DECEASED (Type or print) <u>Sadie Edenfield Jemison</u>			4. DATE OF DEATH Month <u>Mar</u> , Day <u>28</u> , Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>7-26-'23</u>		9. AGE (In years last birthday) <u>34</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sgt. FC U.S. Army</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>	11. BIRTHPLACE (State or foreign country) <u>Florida</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David Edenfield</u>			14. MOTHER'S MAIDEN NAME <u>Ora Lee Waldron</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>1951-</u>	17. INFORMANT Address <u>Mr. David Edenfield, 1419 East North St. Tampa 4, Florida</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> <u>421.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Ischemic heart disease</u> DUE TO (c) <u>Chronic, febrile non-suppurative pneumonitis</u> INTERVAL BETWEEN ONSET AND DEATH <u>Found dead on floor of home 8 days 16 yrs</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Was out for at Walter Reed Hosp.</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/1/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wanner B. Humphrey</u>			ADDRESS <u>SILVER SPRING, MD.</u>	24a. REC'D BY REGISTRAR DATE <u>MAR 31 '58</u>	
			24b. REGISTRAR'S SIGNATURE <u>W. B. Humphrey</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

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BUREAU V. S.

MAR 31 1958

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3549

CERTIFICATE OF DEATH

Reg. Dist. No.

03516

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 28 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 413 East Nelson Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Mary Middle Lula Last Jenkins		4. DATE OF DEATH Month March Day 14 Year 19 58					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 10, 1906	9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME White Baker				14. MOTHER'S MAIDEN NAME Mary Lula Baker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. unknown		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Myeloma 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Pulmonary Edema, Acute Renal Tubular Necrosis, Tetracycline Anaphylaxis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from February 14, 19 58 , to March 14, 19 58 , that I last saw the deceased alive on March 14, 19 58 , and that death occurred at 2:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 3/15/58 National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE Richard K Shaw M.D.		PHYSICIAN'S NAME (Type) RICHARD K. SHAW M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/18/58		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		22d. LOCATION (City, town, or county) (State) ARLINGTON CO. VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE WHEATLEY FUNERAL HOME J S Gentry				ADDRESS ALEXANDRIA, VA.		24a. REC'D BY REGISTRAR DATE MAR 17 '58	
				24b. REGISTRAR'S SIGNATURE Overman			

CERTIFICATE OF DEATH

NEW YORK

BUREAU V. 2

MAR 17 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03517

3550

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Satoma</u>		c. LENGTH OF STAY IN TB <u>5 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Glen Echo</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ropine Nursing Home</u>				d. STREET ADDRESS <u>17 Wellesley Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nellie Jessup</u>				4. DATE OF DEATH <u>3-3-58</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12-1890</u>		9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>W. Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Issac Shriner</u>				14. MOTHER'S MAIDEN NAME <u>Ettie Fore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Nursing Home Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertension</u> (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR. 7, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CUNNINGHAM MEM. PARK</u>		22d. LOCATION (City, town, or county) (State) <u>ST. ALBANS, WEST VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin W. Hyson</u>				ADDRESS <u>1300-N ST. N.W., WASH. D.C.</u>		24a. REC'D BY REGISTRAR <u>Mar 4 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Dee Leach</u>			

RECEIVED

MAR 7 1953

BUREAU V. S.

FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03518

3551

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4847 Crescent St.</u>		d. STREET ADDRESS <u>1 4847 Crescent St.</u>	
3. NAME OF DECEASED (Type or print) <u>Leah Belle</u> First <u>Brooke</u> Middle <u>Johnson</u> Last		4. DATE OF DEATH <u>March</u> Month <u>14</u> Day <u>1958</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 24, 1875</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Lee Brooke</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Coney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-34-2476</u>	
17. INFORMANT <u>Kenneth Marshall</u> Address <u>4847 Crescent St., Chevy Chase, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction due to</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO <u>Diabetes Mellitus</u> (c) <u>5 yr.</u> <u>4 yr.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>January</u> , 19 <u>57</u> , to <u>March 14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>March 13</u> , 19 <u>58</u> , and that death occurred at <u>12:50</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James M. Moss</u> M.D. <u>3805 Florence Dr.</u>		ADDRESS (Street, city or town, state) <u>Alexandria, Va.</u>	
PHYSICIAN'S NAME (Type) <u>James M. Moss</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-17-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>	22d. LOCATION (City, town, or county) (State) <u>Hyattsville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Sewleson-Washington</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>Deborah</u>

BUREAU V. B.

MAR 17 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3466

Film G226 - 100m 17 37/11/58 - mo

CERTIFICATE OF DEATH

03519

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Perry Brooke Johnson, Jr.</u>				4. DATE OF DEATH Month Day Year <u>March 5 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-24-05</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Taxi Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>same</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Perry B. Johnson Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Estelle Blackwell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>577-05-1931</u>		17. INFORMANT Address <u>Admission Record of Wash. San & Hosp.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.1 Congestive heart failure</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. ft. p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>2/26</u> , 19 <u>58</u> , to <u>3/5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/5</u> , 19 <u>58</u> , and that death occurred at <u>6:15 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Eino Magi</u>				ADDRESS (Street, city or town, state) <u>918 University Blvd. E, Silver Spring, Maryland</u>			
M.D. <u>3/6/58</u>				DATE SIGNED <u>3/6/58</u>			
PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 8, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Warrinton Cemetery</u>		22d. LOCATION (City, town, or county), (State) <u>Warrinton, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters, 254 Carroll Ave SE</u>				ADDRESS <u>254 Carroll Ave SE</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 10 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. Search</u>			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3467

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sabona Park near D.O.P.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>1823 Cavenel Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium + Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>David Warren Jones</u>		4. DATE OF DEATH <u>March 19 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-4-57</u>
9. AGE (In years last birthday) <u>4</u> yrs. <u>76</u> Months <u>4</u> Days <u>76</u> Hours <u>19</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Pelton H. Jones</u>		14. MOTHER'S MAIDEN NAME <u>Edna L. Gall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Father</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>391.0</u> DUE TO (b) <u>Bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (c) <u>Acute otitis media (right)</u> (a), stating the underlying cause lost. <u>Severe days -</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2-3 hrs</u> <u>6-8 hrs</u> <u>Severe days -</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>3-20-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>3-22-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town or county) (State) <u>Southview, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home, Inc.</u>		ADDRESS <u>—</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE <u>MAR 24 '58</u>		DATE <u>—</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DATA



BUREAU V. S.

MAR 24 1958

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03521

3552

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery County General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle Arthur Last Jones		4. DATE OF DEATH Month March Day 12 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1.30.70
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months 12 Days 12	11. IF UNDER 24 HRS. Hours 12 Min. 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Samuel H. Jones		14. MOTHER'S MAIDEN NAME Catherine Venable	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock and Acute Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Fracture of left hip (a), stating the underlying cause lost. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 6 days 6 days	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell on floor at home	
20c. TIME OF INJURY Month. Day. Year 10:45 p.m. 3.5. 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Silver Spring, Montg., Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED March 12, 1958	
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE THEREOF March 14, 1958	
22c. NAME OF CEMETERY OR CREMATORY Forest Glen Cemetery		22d. LOCATION (City, town, or county) (State) Forest Glen - Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert H. Tatters		24a. REC'D BY REGISTRAR March 14 58	
24b. REGISTRAR'S SIGNATURE W. J. [Signature]		DATE March 14 58	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MICHIGAN STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: John J. Jones
AGE: 45 SEX: M
DATE OF DEATH: March 14, 1958
PLACE OF DEATH: Home
CAUSE OF DEATH: Heart Disease
MANNER OF DEATH: Natural
SIGNATURE OF EXAMINER: [Signature]
DATE: March 14, 1958

BUREAU V. R.

MAR 14 1958

RECEIVED

John J. Jones
March 14, 1958
John J. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 9, Film G227, 4/11/58 fcy
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

03522

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dayton</u> <u>13X-2</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Arthur</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/20/79</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William John Jones</u>		14. MOTHER'S MAIDEN NAME <u>Mary Squirrel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mary Elizabeth Jones</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>5 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Profound Secondary Anemia 6 months duration</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>47</u> , to <u>March 31</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>March 31</u> , 19 <u>58</u> , and that death occurred at <u>5:40 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Charles S. Whitaker</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Charles S. Whitaker, M. D.</u>		<u>Clarksville, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/4/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Browns Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Dayton, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		ADDRESS <u>Kockville, Md</u>	
24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE <u>DATE</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES EARL RAY		DATE OF DEATH APR 4 1968	
AGE 35		SEX Male	
RACE White		EDUCATION High School	
OCCUPATION Salesman		MARRIED Yes	
BIRTH DATE APR 11 1933		BIRTH PLACE Memphis, Tenn.	
RESIDENCE 1111 1st St. N.E., Wash. D.C.		DECEASED AT 1111 1st St. N.E., Wash. D.C.	
CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural	
IMMEDIATE CAUSE Coronary artery disease		INTERMEDIATE CAUSE Hypertension	
FUNDAMENTAL CAUSE Atherosclerosis		SIGNATURE OF PHYSICIAN [Signature]	
DATE OF SIGNATURE APR 4 1968		PLACE OF SIGNATURE [Signature]	
SIGNATURE OF REGISTRAR [Signature]		DATE OF REGISTRATION APR 4 1968	
PLACE OF REGISTRATION [Signature]		FILING OFFICE [Signature]	
FILING DATE APR 4 1968		FILING TIME [Signature]	
FILING OFFICE [Signature]		FILING TIME [Signature]	

BUREAU V. S.

APR 8 1968

RECEIVED

ORIGINAL FILED

3554

CERTIFICATE OF DEATH

03523

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Washington</u> b. COUNTY <u>D. C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <u>1921 Kalorama Rd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Rest Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lottie</u> Middle <u>E</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>March</u> Day <u>27</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 18, 1872</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>86</u>		IF UNDER 24 HRS. Days <u>86</u> Hours <u>86</u> Min. <u>86</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Albert B. Scrivener</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Robinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Edward H. Jones same as 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-vascular-renal disease with</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>myocardial failure</u> DUE TO (c) <u>3yrs</u> <u>3mos</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x Diabetes Mellitus</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2.19.1958</u> to <u>3.27.1958</u> , that I last saw the deceased alive on <u>3.24.1958</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3921 Ingomar St. N.W.</u> DATE SIGNED <u>3.27.58</u> ACTUAL SIGNATURE <u>Stewart Clapp</u> M.D. <u>Wash 15 D.C.</u> PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/29/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creed</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 31 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Overman</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

445, 2nd Ed. 10

1. PLACE OF DEATH Home		2. SEX Male		3. AGE 42		4. RACE White		5. OCCUPATION Teacher	
6. DATE OF DEATH March 31, 1958		7. TIME OF DEATH 10:30 AM		8. CAUSE OF DEATH Myocardial Infarction		9. MANNER OF DEATH Natural		10. PLACE OF INTERMENT St. Mary's Cemetery	
11. NAME OF DECEASED John Doe		12. DATE OF BIRTH March 15, 1916		13. PLACE OF BIRTH Baltimore, Md.		14. MARITAL STATUS Married		15. EDUCATION High School	
16. NAME OF FATHER John Doe		17. NAME OF MOTHER Jane Doe		18. NAME OF SPOUSE Mary Doe		19. NAME OF CHILDREN None		20. NAME OF GRANDCHILDREN None	
21. NAME OF PHYSICIAN Dr. J. Smith		22. NAME OF HOSPITAL None		23. NAME OF NURSE None		24. NAME OF ASSISTANT None		25. NAME OF ATTENDING None	
26. NAME OF CORONER None		27. NAME OF JURY None		28. NAME OF JUDGE None		29. NAME OF CLERK None		30. NAME OF RECORDS None	
31. NAME OF REGISTRAR None		32. NAME OF CLERK None		33. NAME OF RECORDS None		34. NAME OF ATTENDING None		35. NAME OF PHYSICIAN None	
36. NAME OF NURSE None		37. NAME OF ASSISTANT None		38. NAME OF ATTENDING None		39. NAME OF CORONER None		40. NAME OF JURY None	
41. NAME OF JUDGE None		42. NAME OF CLERK None		43. NAME OF RECORDS None		44. NAME OF ATTENDING None		45. NAME OF PHYSICIAN None	
46. NAME OF NURSE None		47. NAME OF ASSISTANT None		48. NAME OF ATTENDING None		49. NAME OF CORONER None		50. NAME OF JURY None	

BUREAU V. S.

MAR 31 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03524

Reg. Dist. No.

3555

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CARROLL HALL SANITARIUM		d. STREET ADDRESS 3701 CONN. AVE., N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NANNIE Middle M. Last JONES		4. DATE OF DEATH Month MARCH Day 12 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 24, 1883
9. AGE (In years last birthday) 74		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM WINSHIP PARKER		14. MOTHER'S MAIDEN NAME LOUISANA BRINKLEY PARKER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Address MRS. EDITH J. NIEMEYER, DAUGHTER, SAME AS #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.0 Admission / Cocaine & methamphetamine DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 3.45 DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3.45	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Furunculosis - Rheumatoid arthritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-11 , 19 57 , to 3-12 , 19 58 , that I last saw the deceased alive on 2-18 , 19 58 , and that death occurred at 8:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3701 Conn Ave. N.W. Wash DC 20018 DATE SIGNED 3-12-58			
ACTUAL SIGNATURE Irving Burka M.D.		3701 CONN. AVE., N.W., WASH. 8, D.C.	
PHYSICIAN'S NAME (Type) IRVING BURKA			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/14/58	
22c. NAME OF CEMETERY OR CREMATORY OLIVE BRANCH CEM.		22d. LOCATION (City, town, or county) (State) PORTSMOUTH, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's Son Inc ADDRESS 1756 PA. AVE., N.W. DC		24a. REC'D BY REGISTRAR DATE MAR 14 1958	
24b. REGISTRAR'S SIGNATURE Alfred			

YOUNG

S. J. ROSEN

FD-302 (REV. 11-27-70)

1

BUREAU V. S.

MAR 14 1968

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

3468

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville 26</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>4605 Wilburyn Way-Randolph Hills</u>	
3. NAME OF DECEASED (Type or print) First <u>Nettie</u> Middle <u>Katherine</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>3</u> Day <u>30</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-23-65</u>
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clerk</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>Adrian Jones</u>		14. MOTHER'S MAIDEN NAME <u>Mary Moore</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> If yes, give war or dates of service		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Pt's chart</u>		Address <u> </u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia</u> <u>415x</u> <u>Congestive heart failure</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>None</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8/29</u> , 19 <u>56</u> , to <u>3/30</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/30</u> , 19 <u>58</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John B. Umhau</u> M.D.		ADDRESS (Street, city or town, state) <u>8805 Conn. Ave.</u> DATE SIGNED <u>3/30/58</u>	
PHYSICIAN'S NAME (Type) <u>JOHN B. UMHOU</u> <u>Cheng Chose MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>	22b. DATE THEREOF <u>4/2/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lauden Pk Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.W. Lee</u> ADDRESS <u>Wash D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 2 '58</u>	24b. REGISTRAR'S SIGNATURE <u> </u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 21 File 0226 3-10-58 et

CERTIFICATE OF DEATH

03526

Reg. Dist. No.

3556

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 165 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington, D. C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 4908 A Street, S. E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Norman Last Jones			4. DATE OF DEATH Month March Day 1, Year 19 58				
5. SEX Male		6. COLOR OR RACE Negroe		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH October 12, 1909		9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Sylvester Jones				
14. MOTHER'S MAIDEN NAME Ida Marshall			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO. None			17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RETICULUM CELL SARCOMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 200.0 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DUODENAL ULCER WITH HEMORRHAGE							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from September 17, 19 57 , to March 1, 19 58 , that I last saw the deceased alive on March 1, 19 58 , and that death occurred at 8:55 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Richard K Shaw M.D. The Clinical Center 3-2-58 PHYSICIAN'S NAME (Type) Richard K. Shaw, M. D. National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-5-58		22c. NAME OF CEMETERY OR CREMATORY St. Mary's			
22d. LOCATION (City, town, or county) (State) Pisataway Md.		23. FUNERAL DIRECTOR'S SIGNATURE Myrtle K. Rollins		24a. REC'D BY REGISTRAR DATE MAR 6 '58			
24b. REGISTRAR'S SIGNATURE W. Leach							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ATAM POWD

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

RECEIVED
MAR 6 1958
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3557

CERTIFICATE OF DEATH

03527

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE North Carolina b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 59 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mildred Anna Joyner		4. DATE OF DEATH Month Day Year March 15 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 January 1907
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Rassie Ray Whitley		14. MOTHER'S MAIDEN NAME Rebecca Mae Whitley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 190.9 Pulmonary congestion and edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Malignant melanoma with metastasis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 15 January, 1958, to 15 March, 1958, that I last saw the deceased alive on 15 March, 1958, and that death occurred at 7:05 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 3-15-58 National Institutes of Health Bethesda 14, Maryland			
ACTUAL SIGNATURE Roger Lester		M.D.	
PHYSICIAN'S NAME (Type) Roger Lester, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 3/17/58	
22c. NAME OF CEMETERY OR CREMATORY Maplewood		22d. LOCATION (City, town, or county) (State) Wilson N.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home		ADDRESS Wilson N.C.	
24a. REC'D BY REGISTRAR DATE MAR 18 '58		24b. REGISTRAR'S SIGNATURE	

BUREAU V. S.

MAR 18 1958

RECEIVED

3558

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE FLORIDA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA (RURAL)		c. LENGTH OF STAY IN 1b 1 Day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST. PETERSBURG 48X-3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Tammy Middle Alvis Last KAISER		4. DATE OF DEATH Month March Day 29 Year 19 58	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 28, 1958
9. AGE (In years last birthday) yrs. 1		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Martin Jay KAISER		14. MOTHER'S MAIDEN NAME Anne ALVIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Martin Jay KAISER USCG Air Sta.		Address St. Petersburg, Fla.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 762.5 IMMEDIATE CAUSE (a) Prematurity Anoxia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary edema DUE TO (c) Prematurity		INTERVAL BETWEEN ONSET AND DEATH 15 min 1 day 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 28 , 19 58 , to March 29 , 19 58 , that I last saw the deceased alive on March 29 , 19 58 , and that death occurred at 2:41 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital DATE SIGNED 3-31-58			
ACTUAL SIGNATURE Kenneth W. Sell M.D.			
PHYSICIAN'S NAME (Type) K. W. SELL LT MC USNR		Bethesda, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 4-2-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pappas		24a. REC'D BY REGISTRAR APR 3 '58	
ADDRESS Bethesda, Md.		24b. REGISTRAR'S SIGNATURE W. J. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF MARYLAND

DEPARTMENT OF HEALTH

U. S. DEPARTMENT OF HEALTH, WASHINGTON, D. C.

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Burial Officer

Signature of Undertaker

Signature of Minister

Signature of Priest

Signature of Rabbi

Signature of Imam

BUREAU V. S.

APR 3 1933

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3559

CERTIFICATE OF DEATH

03529

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY F.P.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Ranier 1616-2 ✓	
d. STREET ADDRESS 3300 Chauncey Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Viola Middle (nm) Last KALMUS		4. DATE OF DEATH Month March Day 10 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 March 1890
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry AFACHLER		14. MOTHER'S MAIDEN NAME Eve AFACHLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT (Son) Joseph Kalmus, 1704 Glen Park Drive,		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Infarction of Myocardium 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 48 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9 March , 19 58 , to 10 March , 19 58 , that I last saw the deceased alive on 10 March , 19 58 , and that death occurred at 7:05A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE G.E. Gorsuch		ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 3-10-58	
PHYSICIAN'S NAME (Type) G.E. GORSUCH, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-12-58	
22c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery		22d. LOCATION (City, town, or county) (State) Hyattsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Goldberg's, 4217 9th St. N.W. Washington, D.C.		24a. REC'D BY REGISTRAR DATE MAR 12 '58	
24b. REGISTRAR'S SIGNATURE W. H. ...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

FILE NO. 1234

DATE OF DEATH

PLACE OF DEATH

(M-1)

CAUSE OF DEATH

PLACE OF BIRTH

None

DATE OF BIRTH

(M-1)

PLACE OF BIRTH

STATE OF BIRTH

BUREAU V. R.

MAR 12 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3560 CERTIFICATE OF DEATH

03530

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington			c. LENGTH OF STAY IN 1b 47 x -3			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Nursing Home				d. STREET ADDRESS 1498 Spring Place N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LILLIAN E Kephart				4. DATE OF DEATH Month March Day 3 Year 1958			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/11/1866	
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Clerk Agriculture Dept.				10b. KIND OF BUSINESS OR INDUSTRY Jefferson W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Lewis Kephart				14. MOTHER'S MAIDEN NAME Emily B. Moler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Tupelo, Miss. Mrs. C. W. Shaw -435 N. Robins St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio sclerotic heart disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 4 mos 5 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1) fractured femur see 579049							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June , 19 57 , to March 3 , 19 58 , that I lost saw the deceased alive on March 3 , 19 58 , and that death occurred at 12:30 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Washington D C DATE SIGNED 3/3/58							
ACTUAL SIGNATURE [Signature] M.D. 7852 16 4 W				PHYSICIAN'S NAME (Type) B. F. Kreuzburg			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 3/5/58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, D. C.				24a. REC'D BY REGISTRAR DATE MAR 6 1958		24b. REGISTRAR'S SIGNATURE [Signature]	

BUREAU V. 1

1958 6 MAR

RECEIVED

3561

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>DC</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47x-3 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>2138 California St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>7.</u> Last <u>Kluckhohn</u>		4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 6 1877</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>USA (Chicago, Ill.)</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Dodson</u>		14. MOTHER'S MAIDEN NAME <u>Jeanette Hamilton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>7 FRANK L.</u>	
17. INFORMANT <u>Son</u> Address <u>2138 California St. N.W. Washington DC</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>593x</u> DUE TO <u>thromia due to chronic renal failure.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE: CONDITION GIVEN IN PART I (a) <u>Left ventricular failure due to atherosclerotic heart disease.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 19, 1958</u> to <u>March 19, 1958</u> that I last saw the deceased alive on <u>March 19, 1958</u> , and that death occurred at <u>11:00</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George A. Ray, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>104 Cherry Chase Dr. Hydr Park Cok C. Ill.</u> DATE SIGNED <u>Cherry Chase 15, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>George A. GRAY JR.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	22b. DATE THEREOF <u>3-21-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Woods Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hydr Park Cok C. Ill.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. CHAMBERS CO</u> ADDRESS <u>1400 Chapin St. N.W.</u>		24. REC'D BY REGISTRAR <u>24 MAR 24 58</u> 24b. REGISTRAR'S SIGNATURE <u>Reed</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH



BUREAU V. S.

MAR 24 1958

RECEIVED

3562 *Item 9 Film 227 3-28-58 et*
CERTIFICATE OF DEATH

03532

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 9408 Kingsley Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elsie Middle Knopf Last Knopf		4. DATE OF DEATH Month March Day 20 Year 1958	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-16-82
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Not Known		14. MOTHER'S MAIDEN NAME NOT KNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Melvin Knopf		Address Detroit, Mich.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute hemorrhagic pancreatitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Infectious Hepatitis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 days 2 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/5 , 19 58 , to 3/20 , 19 58 , that I last saw the deceased alive on 3/20 , 19 58 , and that death occurred at 2:30 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Georgin Ave Silver Spring Md DATE SIGNED 3/20/58			
ACTUAL SIGNATURE John J. Curry M.D.		PHYSICIAN'S NAME (Type) John J. Curry, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 23, 1958	
22c. NAME OF CEMETERY OR CREMATORY Beth El Cemetery		22d. LOCATION (City, town, or county) (State) Detroit, Mich.	
23. FUNERAL DIRECTOR'S SIGNATURE B. Dargatzsky		ADDRESS 3501-14 St. N.W.	
24a. REC'D BY REGISTRAR MAR 24 '58		24b. REGISTRAR'S SIGNATURE Albe...	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03533

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>13315 Grenoble Dr</u>		d. STREET ADDRESS <u>13315 Grenoble Dr</u>	
3. NAME OF DECEASED (Type or print) <u>Stanley Hodges Knox Jr</u>		4. DATE OF DEATH <u>Mar 11 1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-26-'57</u>
9. AGE (In years last birthday) <u>3</u> yrs. <u>15</u> Months <u>15</u> Days		IF UNDER 1 YEAR IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Stanley H. Knox</u>		14. MOTHER'S MAIDEN NAME <u>Shirley Gregory</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>father -</u>	
17. INFORMANT <u>Stanley H. Knox</u>		Address <u>John 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>475X</u> DUE TO <u>Asphyxia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Vomiting, asphyxiated</u> DUE TO <u>Asphyxia</u> (c) <u>Upper Respiratory Infection</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Mar 11 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/14/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>MAR 14 58</u>		DATE <u>Mar 11 1958</u>	
24b. REGISTRAR'S SIGNATURE <u>W. E. Humphrey</u>			

2077232XV5

RECEIVED

MAR 14 1958

BUREAU V. S.

STATE
HEALTH DEPT

STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03534

3564

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sandy Spring</u>				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Hyatt</u> Last <u>Lansdale</u>				4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10.27.83</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>County Commissioner, Mont. County, Md.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>(retired)</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Franklin Thomas Lansdale</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Lindsey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>218-30-4302</u>		17. INFORMANT <u>Hospital Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>?</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2.1.57</u> , 1957, to <u>2.18</u> , 1958, that I last saw the deceased alive on <u>2.18</u> , 1958, and that death occurred at <u>11:00pm</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. W. Bird</u>				ADDRESS (Street, city or town, state) <u>Sandy Spring, Maryland</u>			
DATE SIGNED <u>3/19/58</u>							
PHYSICIAN'S NAME (Type) <u>J. W. Bird, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>3/21/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Episcopal Church Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Maryland</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter G. Pumphrey</u>				ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR <u>W. J. ...</u>	
24b. REGISTRAR'S SIGNATURE							

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

3565

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Richard Middle Michael Last Leck		4. DATE OF DEATH Month March Day 6 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 14, 1953
9. AGE (In years last birthday) 4 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Michael Anthony Leck		14. MOTHER'S MAIDEN NAME Mary Wojtkowski	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest, Clinical, Postoperative. 754.2 DUE TO Congenital Heart Disease - Ventricular Septal Defect, status postoperative repair. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) Congestion, Lungs, Liver, Spleen, Kidneys. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 2, 1958 , to March 6, 1958 , that I last saw the deceased alive on March 6, 1958 , and that death occurred at 9:00P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Carlos R. Lombardo M.D.		ADDRESS (Street, city or town, state) The Clinical Center 3/7/58 National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) CARLOS R. LOMBARDO, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit	22b. DATE THEREOF 3/7/1958	22c. NAME OF CEMETERY OR CREMATORY Holy Cross.	22d. LOCATION (City, town, or county) (State) N. Arlington New Jersey
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md		24a. REC'D BY REGISTRAR MAR 12 '58 DATE	
		24b. REGISTRAR'S SIGNATURE Robert A. Pumphrey	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12 MAR 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3567

CERTIFICATE OF DEATH

03537

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL (COLNEY)</u>		c. LENGTH OF STAY IN 1b <u>3 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL (COLNEY) X</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Emory Lane & Ga. Ave.</u>				d. STREET ADDRESS <u>EMORY LANE + GEORGIA AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GRACE JOSEPHA LEIMBACH</u>				4. DATE OF DEATH Month Day Year <u>3 11 1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 1 1889</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min <u>X</u> <u>X</u> <u>X</u> <u>X</u>		IF UNDER 24 HRS. Months Days Hours Min <u>X</u> <u>X</u> <u>X</u> <u>X</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>SCRANTON PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>			
13. FATHER'S NAME <u>EDWARD QUIGLEY</u>				14. MOTHER'S MAIDEN NAME <u>Bridget O'Rourke</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>LEONARD L. LEIMBACH</u> Address <u>213 C. ST. N.W. WASHINGTON D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA PANCREAS</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 WEEKS</u> <u>3 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-30</u> , 19 <u>57</u> , to <u>3-11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3-9</u> , 19 <u>58</u> , and that death occurred at <u>4:35 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James C Mandes</u> M.D. <u>1801 K ST. N.W. WASHINGTON D.C.</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>3-11-58</u>			
PHYSICIAN'S NAME (Type) <u>JAMES C MANDES</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>ENTOMBMENT</u>		22b. DATE THEREOF <u>3/14/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED: JOHN J. BROWN</p>		<p>2. SEX: Male</p>	
<p>3. AGE: 65</p>		<p>4. DATE OF BIRTH: 1893</p>	
<p>5. PLACE OF BIRTH: NEW YORK</p>		<p>6. OCCUPATION: None</p>	
<p>7. CAUSE OF DEATH: Heart Disease</p>		<p>8. MANNER OF DEATH: Natural</p>	
<p>9. DATE OF DEATH: March 14, 1958</p>		<p>10. TIME OF DEATH: 10:00 AM</p>	
<p>11. PLACE OF DEATH: Home</p>		<p>12. SIGNATURE OF PHYSICIAN: [Signature]</p>	
<p>13. SIGNATURE OF REGISTRAR: [Signature]</p>		<p>14. SIGNATURE OF WITNESS: [Signature]</p>	

BUREAU V. 2

MAR 14 1958

RECEIVED

3566

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				d. STREET ADDRESS Route # 3 Box 138			
3. NAME OF DECEASED (Type or print) First Norman Middle William Last Leizear				4. DATE OF DEATH Month March Day 12 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 14 1909	9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov.		11. BIRTHPLACE (State or foreign country) Maryland (Prince Geo.)		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Elisah Leizear				14. MOTHER'S MAIDEN NAME Beulah Taylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1941-45		17. INFORMANT Address Mrs. Isabelle Leizear (Wife)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Infarction, left postapical area 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombosis, left middle cerebral artery DUE TO (c) Hypertensive Cardiovascular							INTERVAL BETWEEN ONSET AND DEATH 5 Days 5 Days years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X Bilateral Confluent Bronchopneumonia							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 3-7, 1958 to 3-12, 1958 that I last saw the deceased alive on 3-11, 1958 , and that death occurred on 3-12, 1958 from the causes and on the date stated above.							
ACTUAL SIGNATURE W. G. Hall				ADDRESS (Street, city or town, state) 615 W. Montgomery Ave. Rockville, Md.			
PHYSICIAN'S NAME (Type) W. G. Hall				DATE SIGNED 3/13/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/14/58		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE West of Pumphrey				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE MAR 17 '58	
				24b. REGISTRAR'S SIGNATURE Overman			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2288

RECEIVED
MAR 17 1958
BUREAU V. S.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3469 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03538

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY in 1b <u>D. O. A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sligo Creek at Carroll Avenue</u>				d. STREET ADDRESS <u>8109 Carroll Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lilly</u> First <u>XXXX</u> Middle <u>V.</u> Last <u>Lilley</u>		4. DATE OF DEATH Month <u>March</u> Day <u>9</u> Year <u>19 58</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 2, 1888</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Pugh</u> <u>David Pugh</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Takoma Park Police</u> Address <u></u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>932.8 Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>exposure</u> (a), stating the underlying cause lost. DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead in Sligo Creek - Carcinoma of rectum</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>exposure</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a. m. <u>3-9</u> p. m. <u>1958</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Takoma Pk.</u>		20f. (City or town) <u>Montg.</u>		20g. (County) <u>md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Brochart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Brochart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 12, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sanage Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Sanage Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>He Witt Caldwell, Laurel, Md</u>				24a. REC'D BY REGISTRAR <u>Mar 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Reed</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND
HEALTH DEPT.

BUREAU V. P.

MAR 17 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03539

Reg. Dist. No.

3568

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 44 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Irving Middle David Last Lipman		4. DATE OF DEATH Month March Day 20 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 18, 1907
9. AGE (In years last birthday) 50		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manufacturer		10b. KIND OF BUSINESS OR INDUSTRY Manufacturing	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Lipman		14. MOTHER'S MAIDEN NAME Rose Lichtman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Unascertainable	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TRACHEAL OBSTRUCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTATIC ANAPLASTIC CARCINOMA OF (c) RHINOPHARYNX			INTERVAL BETWEEN ONSET AND DEATH 7 DAYS 14 MONTHS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) TETANY DUE TO RESPIRATORY ALKALOSIS, BRONCHOPNEUMONIA			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 4, 1958 , to March 20, 1958 , that I last saw the deceased alive on March 20, 1958 , and that death occurred at 11:45 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Richard K. Shaw		ADDRESS (Street, city or town, state) The Clinical Center The National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) Richard K. Shaw, M. D.		DATE SIGNED 3-21-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 23, 1958	22c. NAME OF CEMETERY OR CREMATORY Mt. Ararat Cemetery	22d. LOCATION (City, town, or county) (State) Farmingdale, Long Island, N.Y.
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons		ADDRESS Wash., 10, D. C. 3501 14th St., N.W.	
24a. REG'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE W. H. Smith	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MAR 24 1958

RECEIVED

BUREAU Y. H.

3569

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Clark St. Mary			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NNMC, Bethesda Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Vicki Middle Lynn Last LOGSDON				4. DATE OF DEATH Month March Day 9 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9 March 1958	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months 3 Days 41		IF UNDER 24 HRS. Hours 3 Min. 41			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Donald R. LOGSDON				14. MOTHER'S MAIDEN NAME Katherine D. WHISMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT (Father,) Donald R. Logsdon (same as #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Inmaturity DUE TO (c) Inmaturity PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 9 March , 19 58 , to 9 March 1958 , that I last saw the deceased alive on D.O.A. , 19 58 , and that death occurred at 4:10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 3-10-58 ACTUAL SIGNATURE Russell Miller, Jr. M.D. PHYSICIAN'S NAME (Type) Russell Miller, Jr. LT, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-12-58		22c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery		22d. LOCATION (City, town, or county) (State) Great Mills, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Mattingly's, Leonardtown, Maryland				ADDRESS		24a. REC'D BY REGISTRAR DATE MAR 14 '58	
24b. REGISTRAR'S SIGNATURE W. Beach							

MEDICAL CERTIFICATION

2

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CERTIFICATE OF DEATH

1933

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

RECEIVED

RECEIVED

MAR 14 1933

BUREAU V. S.

Item 8, Film G227, 4/11/58, fcy

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery 3570 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle John Last Lomax		4. DATE OF DEATH Month March Day 25 Year 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 80 12/25/78
9. AGE (In years lost birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A./	
13. FATHER'S NAME William Lomax		14. MOTHER'S MAIDEN NAME Louise Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Emanuel H. Lomax		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Uremia DUE TO (b) Lobar Pneumonia R.h. DUE TO (c) Hypertensive Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 1 wk. 1 wk. Yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 490X			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3/22, 1958 , to 3/25, 1958 , that I last saw the deceased alive on 3/25, 1958 , and that death occurred at 6:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE C. H. Ligon, M.D.		M.D. Sandy Spring, Maryland	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	3/28/58	St. Pleasant	Norbeck, Md
23. FUNERAL DIRECTOR'S SIGNATURE Robert K. Sunder		ADDRESS Rockville, Md	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE DATE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES M. SMITH		2. SEX Male		3. AGE 45	
4. PLACE OF BIRTH Baltimore, Md.		5. OCCUPATION Salesman		6. MARITAL STATUS Married	
7. DATE OF DEATH March 31, 1958		8. TIME OF DEATH 10:15 AM		9. PLACE OF DEATH Home	
10. CAUSE OF DEATH Myocardial Infarction		11. DISEASE OR INJURY Coronary Artery Disease		12. MANNER OF DEATH Natural	
13. SIGNATURE OF PHYSICIAN J. H. Smith, M.D.		14. SIGNATURE OF REGISTRAR J. H. Smith, M.D.		15. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
16. SIGNATURE OF DECEASED J. H. Smith		17. SIGNATURE OF SURVIVORS J. H. Smith		18. SIGNATURE OF OTHERS J. H. Smith	
19. SIGNATURE OF DECEASED J. H. Smith		20. SIGNATURE OF SURVIVORS J. H. Smith		21. SIGNATURE OF OTHERS J. H. Smith	
22. SIGNATURE OF DECEASED J. H. Smith		23. SIGNATURE OF SURVIVORS J. H. Smith		24. SIGNATURE OF OTHERS J. H. Smith	
25. SIGNATURE OF DECEASED J. H. Smith		26. SIGNATURE OF SURVIVORS J. H. Smith		27. SIGNATURE OF OTHERS J. H. Smith	
28. SIGNATURE OF DECEASED J. H. Smith		29. SIGNATURE OF SURVIVORS J. H. Smith		30. SIGNATURE OF OTHERS J. H. Smith	
31. SIGNATURE OF DECEASED J. H. Smith		32. SIGNATURE OF SURVIVORS J. H. Smith		33. SIGNATURE OF OTHERS J. H. Smith	
34. SIGNATURE OF DECEASED J. H. Smith		35. SIGNATURE OF SURVIVORS J. H. Smith		36. SIGNATURE OF OTHERS J. H. Smith	
37. SIGNATURE OF DECEASED J. H. Smith		38. SIGNATURE OF SURVIVORS J. H. Smith		39. SIGNATURE OF OTHERS J. H. Smith	
40. SIGNATURE OF DECEASED J. H. Smith		41. SIGNATURE OF SURVIVORS J. H. Smith		42. SIGNATURE OF OTHERS J. H. Smith	
43. SIGNATURE OF DECEASED J. H. Smith		44. SIGNATURE OF SURVIVORS J. H. Smith		45. SIGNATURE OF OTHERS J. H. Smith	
46. SIGNATURE OF DECEASED J. H. Smith		47. SIGNATURE OF SURVIVORS J. H. Smith		48. SIGNATURE OF OTHERS J. H. Smith	
49. SIGNATURE OF DECEASED J. H. Smith		50. SIGNATURE OF SURVIVORS J. H. Smith		51. SIGNATURE OF OTHERS J. H. Smith	
52. SIGNATURE OF DECEASED J. H. Smith		53. SIGNATURE OF SURVIVORS J. H. Smith		54. SIGNATURE OF OTHERS J. H. Smith	
55. SIGNATURE OF DECEASED J. H. Smith		56. SIGNATURE OF SURVIVORS J. H. Smith		57. SIGNATURE OF OTHERS J. H. Smith	
58. SIGNATURE OF DECEASED J. H. Smith		59. SIGNATURE OF SURVIVORS J. H. Smith		60. SIGNATURE OF OTHERS J. H. Smith	
61. SIGNATURE OF DECEASED J. H. Smith		62. SIGNATURE OF SURVIVORS J. H. Smith		63. SIGNATURE OF OTHERS J. H. Smith	
64. SIGNATURE OF DECEASED J. H. Smith		65. SIGNATURE OF SURVIVORS J. H. Smith		66. SIGNATURE OF OTHERS J. H. Smith	
67. SIGNATURE OF DECEASED J. H. Smith		68. SIGNATURE OF SURVIVORS J. H. Smith		69. SIGNATURE OF OTHERS J. H. Smith	
70. SIGNATURE OF DECEASED J. H. Smith		71. SIGNATURE OF SURVIVORS J. H. Smith		72. SIGNATURE OF OTHERS J. H. Smith	
73. SIGNATURE OF DECEASED J. H. Smith		74. SIGNATURE OF SURVIVORS J. H. Smith		75. SIGNATURE OF OTHERS J. H. Smith	
76. SIGNATURE OF DECEASED J. H. Smith		77. SIGNATURE OF SURVIVORS J. H. Smith		78. SIGNATURE OF OTHERS J. H. Smith	
79. SIGNATURE OF DECEASED J. H. Smith		80. SIGNATURE OF SURVIVORS J. H. Smith		81. SIGNATURE OF OTHERS J. H. Smith	
82. SIGNATURE OF DECEASED J. H. Smith		83. SIGNATURE OF SURVIVORS J. H. Smith		84. SIGNATURE OF OTHERS J. H. Smith	
85. SIGNATURE OF DECEASED J. H. Smith		86. SIGNATURE OF SURVIVORS J. H. Smith		87. SIGNATURE OF OTHERS J. H. Smith	
88. SIGNATURE OF DECEASED J. H. Smith		89. SIGNATURE OF SURVIVORS J. H. Smith		90. SIGNATURE OF OTHERS J. H. Smith	
91. SIGNATURE OF DECEASED J. H. Smith		92. SIGNATURE OF SURVIVORS J. H. Smith		93. SIGNATURE OF OTHERS J. H. Smith	
94. SIGNATURE OF DECEASED J. H. Smith		95. SIGNATURE OF SURVIVORS J. H. Smith		96. SIGNATURE OF OTHERS J. H. Smith	
97. SIGNATURE OF DECEASED J. H. Smith		98. SIGNATURE OF SURVIVORS J. H. Smith		99. SIGNATURE OF OTHERS J. H. Smith	
100. SIGNATURE OF DECEASED J. H. Smith		101. SIGNATURE OF SURVIVORS J. H. Smith		102. SIGNATURE OF OTHERS J. H. Smith	

BUREAU V. S.

MAR 31 1958

RECEIVED

3571

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE LOUISIANA b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA RURAL				c. LENGTH OF STAY IN 1b 2 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. NAVAL HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ALEXANDRIA 56 X-3			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First GEORGE Middle SHANNON Last LONG				4. DATE OF DEATH Month 3 Day 22 Year 1958			
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-11-1883		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Politics		10b. KIND OF BUSINESS OR INDUSTRY Politics		11. BIRTHPLACE (State or foreign country) Louisiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Huey P. LONG, Sr.				14. MOTHER'S MAIDEN NAME Callie TISON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO.		17. INFORMANT Jewell Irene LONG 2136 31st ST., Washington, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Wall with Cardiac Tamponade DUE TO (b) Myocardial Infarction DUE TO (c) Coronary Artery Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 10 mins. 2 days 2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 20 March , 19 58 , to 22 March , 19 58 , that I last saw the deceased alive on 22 March , 19 58 , and that death occurred at 1:55 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. NAVAL HOSPITAL, BETHESDA, MD. DATE SIGNED 3-22-58							
ACTUAL SIGNATURE F. S. Caldwell M.D.							
PHYSICIAN'S NAME (Type) F. S. CALDWELL LT MC USN							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-27-58		22c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		22d. LOCATION (City, town, or county) (State) Pineville, Louisiana	
23. BURIAL DIRECTOR'S SIGNATURE Joseph Gawler's & Sons				ADDRESS 1756 Pennsylvania Ave..NW, Wash. DC		24b. REGISTRAR'S SIGNATURE Alfred	
				24a. REC'D BY REGISTRAR MAR 26 '58			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
EDUCATION		RELIGION		MARITAL STATUS	
SIGNED		WITNESSED		CERTIFIED	

RECEIVED
MAR 26 1958
BUREAU A. R.

3470

CERTIFICATE OF DEATH

Reg. Dist. No.

03543

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. LENGTH OF STAY IN 1b <u>26 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CHARLES ALEXANDER LOWE</u>				4. DATE OF DEATH <u>MARCH 2 1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WH</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/1/79</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Circulation Dept. Man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Times Herald</u>		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE W. LOWE</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Ann Wood</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Pl's sister on chart</u> Address <u>Caroline Rieseberg</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inanition</u> same as #2 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Left Lung</u> DUE TO (c) <u>Terminal</u> 2410							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-28</u> , 19 <u>58</u> , to <u>3-2</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3-1</u> , 19 <u>58</u> , and that death occurred at <u>3:20 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Hare</u> M.D.				ADDRESS (Street, city or town, state) <u>Takoma Park, Md.</u> DATE SIGNED <u>3/3/58</u>			
PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>3/4/58</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>H. Lincoln Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. H. Hine Co</u> ADDRESS <u>2901-14th St. N.W. Wash. D.C.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE <u>MAR 4 '58</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 100-100

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]	
4. DATE OF DEATH [REDACTED]		5. TIME OF DEATH [REDACTED]		6. PLACE OF DEATH [REDACTED]	
7. CAUSE OF DEATH [REDACTED]		8. MANNER OF DEATH [REDACTED]		9. PLACE OF BIRTH [REDACTED]	
10. DATE OF BIRTH [REDACTED]		11. SEX OF BIRTH [REDACTED]		12. PLACE OF BIRTH [REDACTED]	
13. DATE OF DEATH [REDACTED]		14. TIME OF DEATH [REDACTED]		15. PLACE OF DEATH [REDACTED]	
16. CAUSE OF DEATH [REDACTED]		17. MANNER OF DEATH [REDACTED]		18. PLACE OF BIRTH [REDACTED]	
19. DATE OF BIRTH [REDACTED]		20. SEX OF BIRTH [REDACTED]		21. PLACE OF BIRTH [REDACTED]	
22. DATE OF DEATH [REDACTED]		23. TIME OF DEATH [REDACTED]		24. PLACE OF DEATH [REDACTED]	
25. CAUSE OF DEATH [REDACTED]		26. MANNER OF DEATH [REDACTED]		27. PLACE OF BIRTH [REDACTED]	
28. DATE OF BIRTH [REDACTED]		29. SEX OF BIRTH [REDACTED]		30. PLACE OF BIRTH [REDACTED]	
31. DATE OF DEATH [REDACTED]		32. TIME OF DEATH [REDACTED]		33. PLACE OF DEATH [REDACTED]	
34. CAUSE OF DEATH [REDACTED]		35. MANNER OF DEATH [REDACTED]		36. PLACE OF BIRTH [REDACTED]	
37. DATE OF BIRTH [REDACTED]		38. SEX OF BIRTH [REDACTED]		39. PLACE OF BIRTH [REDACTED]	
40. DATE OF DEATH [REDACTED]		41. TIME OF DEATH [REDACTED]		42. PLACE OF DEATH [REDACTED]	
43. CAUSE OF DEATH [REDACTED]		44. MANNER OF DEATH [REDACTED]		45. PLACE OF BIRTH [REDACTED]	
46. DATE OF BIRTH [REDACTED]		47. SEX OF BIRTH [REDACTED]		48. PLACE OF BIRTH [REDACTED]	
49. DATE OF DEATH [REDACTED]		50. TIME OF DEATH [REDACTED]		51. PLACE OF DEATH [REDACTED]	
52. CAUSE OF DEATH [REDACTED]		53. MANNER OF DEATH [REDACTED]		54. PLACE OF BIRTH [REDACTED]	
55. DATE OF BIRTH [REDACTED]		56. SEX OF BIRTH [REDACTED]		57. PLACE OF BIRTH [REDACTED]	
58. DATE OF DEATH [REDACTED]		59. TIME OF DEATH [REDACTED]		60. PLACE OF DEATH [REDACTED]	
61. CAUSE OF DEATH [REDACTED]		62. MANNER OF DEATH [REDACTED]		63. PLACE OF BIRTH [REDACTED]	
64. DATE OF BIRTH [REDACTED]		65. SEX OF BIRTH [REDACTED]		66. PLACE OF BIRTH [REDACTED]	
67. DATE OF DEATH [REDACTED]		68. TIME OF DEATH [REDACTED]		69. PLACE OF DEATH [REDACTED]	
70. CAUSE OF DEATH [REDACTED]		71. MANNER OF DEATH [REDACTED]		72. PLACE OF BIRTH [REDACTED]	
73. DATE OF BIRTH [REDACTED]		74. SEX OF BIRTH [REDACTED]		75. PLACE OF BIRTH [REDACTED]	
76. DATE OF DEATH [REDACTED]		77. TIME OF DEATH [REDACTED]		78. PLACE OF DEATH [REDACTED]	
79. CAUSE OF DEATH [REDACTED]		80. MANNER OF DEATH [REDACTED]		81. PLACE OF BIRTH [REDACTED]	
82. DATE OF BIRTH [REDACTED]		83. SEX OF BIRTH [REDACTED]		84. PLACE OF BIRTH [REDACTED]	
85. DATE OF DEATH [REDACTED]		86. TIME OF DEATH [REDACTED]		87. PLACE OF DEATH [REDACTED]	
88. CAUSE OF DEATH [REDACTED]		89. MANNER OF DEATH [REDACTED]		90. PLACE OF BIRTH [REDACTED]	
91. DATE OF BIRTH [REDACTED]		92. SEX OF BIRTH [REDACTED]		93. PLACE OF BIRTH [REDACTED]	
94. DATE OF DEATH [REDACTED]		95. TIME OF DEATH [REDACTED]		96. PLACE OF DEATH [REDACTED]	
97. CAUSE OF DEATH [REDACTED]		98. MANNER OF DEATH [REDACTED]		99. PLACE OF BIRTH [REDACTED]	
100. DATE OF BIRTH [REDACTED]		101. SEX OF BIRTH [REDACTED]		102. PLACE OF BIRTH [REDACTED]	

BUREAU V. S.

MAR 4 1958

RECEIVED

3572

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1917 Grace Church Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>L.</u> Last <u>Low</u>				4. DATE OF DEATH Month <u>3</u> Day <u>30</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 10, 1867</u>	
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>20</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S</u>	
13. FATHER'S NAME <u>Benjamin F. Larcombe</u>				14. MOTHER'S MAIDEN NAME <u>Margaret E. Stewart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Howard Larcombe 08422 Ga. Ave. S. S.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MYOCARDIAL INFARCTION</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>10 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1948</u> to <u>30 MARCH</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>28 MARCH</u> , 19 <u>58</u> , and that death occurred at <u>2 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. B. Snow</u>				ADDRESS (Street, city or town, state) <u>9013 FLOWER AVE. SILVER SPRING, MARYLAND</u>			
PHYSICIAN'S NAME (Type) <u>L. B. Snow</u>				DATE SIGNED <u>3/30/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/1/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>			
24a. REC'D BY REGISTRAR <u>APR 3 '58</u>				24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 3 1958

3573

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring - 56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Lebeau Gardens Nursing Home		d. STREET ADDRESS 1024 University Blvd.	
3. NAME OF DECEASED (Type or print) Emma Lee Mason		4. DATE OF DEATH March 28 19 58	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 27 - 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	9. AGE (In years last birthday) yrs. 70 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) Henry County Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mr. E. Cooper		14. MOTHER'S MAIDEN NAME Madny	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Lawrence B. Mason		Address 8416 Lincy Dr. Court St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pelvic Malignancy (Uterine?) DUE TO (c) Venous Obstruction, Pelvic INTERVAL BETWEEN ONSET AND DEATH 53 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY a. H. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb 26 19 58 to Mar 28 19 58 , that I last saw the deceased alive on Mar 26 19 58 , and that death occurred at 11:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert T. Thibadeau		ADDRESS (Street, city or town, state) 10609 Concord St. DATE SIGNED Mar 28 58	
PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D.		Kensington, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar 31 1958	22c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	22d. LOCATION (City, town, or county) (State) Roadside Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Robert T. Thibadeau		ADDRESS 254 S. 13th St. W.	24a. REC'D BY REGISTRAR MAR 31 '58 DATE
		24b. REGISTRAR'S SIGNATURE W. B. Beach	

CERTIFICATE OF DEATH

Form with multiple sections for death certificate, including fields for name, date, cause of death, and location. The form is mostly blank with some faint markings.

BURAU V. S.

MAR 31 1953

RECEIVED

Handwritten signatures and dates at the bottom of the form, including "MAR 31 1953" and "MAR 31 1953".

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03546

3574

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Brooke Road		d. STREET ADDRESS 1013 8th St., N.W.	
3. NAME OF DECEASED (Type or print) Joshua Mathews		4. DATE OF DEATH Mar. 30, 1958 19	
5. SEX male	6. COLOR OR RACE col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/22/19/15
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gilbert Mathews		14. MOTHER'S MAIDEN NAME Minerva Selby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Montg Co. Police Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock due to rupture of diaphragm and atelectasis of both lungs & hemorrhage shot gun wound in upper left abdomen DUE TO (b) Laceration of spleen & Severance of transverse colon DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1/2 hr.			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot by brother with 12 Ga. shot gun	
20c. TIME OF INJURY Month, Day, Year 12:40 p.m. 3/30/58	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	20f. (City or town) (County) (State) Sandy Spring Montg, Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Mar. 30, 1958	
22a. BURIAL, CREMATION, REMAINS (Type)	22b. DATE THEREOF 4/3/58	22c. NAME OF CEMETERY OR CREMATORY Ash Memorial,	22d. LOCATION (City, town, or county) (State) Sandy Spring, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		ADDRESS Rockville, Md.	
24a. REC'D BY REGISTRAR DATE APR 8 '58		24b. REGISTRAR'S SIGNATURE W. H. H. H.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE STATE
HEALTH DEPT



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

POST MORTEM	
Name of the deceased	
Age	
Sex	
Race	
Date of death	
Place of death	
Cause of death	
Manner of death	
Signature of Medical Examiner	
Signature of Coroner	
Signature of Police	
Signature of Burial	
Signature of Registrar	
Signature of Clerk	
Signature of Nurse	
Signature of Doctor	
Signature of Pharmacist	
Signature of Dentist	
Signature of Minister	
Signature of Priest	
Signature of Rabbi	
Signature of Imam	
Signature of Other	

BUREAU V. S.

APR 8 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3471

CERTIFICATE OF DEATH

03547

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D.C.</i> b. COUNTY <i>Washington</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington D.C. - 15</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium + Hosp.</i>		d. STREET ADDRESS <i>5420 Connecticut Ave N.W.</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Robert Buchanan McCandless</i>		4. DATE OF DEATH Month <i>3</i> Day <i>11</i> Year <i>1958</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-1-85</i>
9. AGE (In years last birthday) <i>72</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired - Deputy Controller</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Iowa</i>	
11. BIRTHPLACE (State or foreign country) <i>Iowa</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John McCandless</i>		14. MOTHER'S MAIDEN NAME <i>Kate Buchanan</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>None</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Washington San + Hosp Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Inter. Cerebrovascular Infarction</i> DUE TO <i>Atherosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Who knows</i> DUE TO (c) <i>Who knows</i> INTERVAL BETWEEN ONSET AND DEATH <i>11 days</i> <i>yes</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Moderate overweight</i>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1950</i> to <i>3/11/1958</i> , that I last saw the deceased alive on <i>3/11/1958</i> , and that death occurred at <i>8:00 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Chas. H. Wolotton</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>500 Underwood St N.W. 3/11/58</i>	
PHYSICIAN'S NAME (Type) <i>Chas. H. Wolotton</i>		<i>Washington, D.C.</i>	
22a. BURIAL, CREMATION, REBURY (Specify)		22b. DATE THEREOF	
<i>Burial</i>		<i>3-13-58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>East Lawn</i>		22d. LOCATION (City, town, or county) (State) <i>Sheldon Iowa</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph E. Sanders, Sons</i>		ADDRESS <i>1756 Penn Ave Washington, D. C.</i>	
24a. REC'D BY REGISTRAR <i>DATE MAR 13 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Overman</i>	

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03548

3575

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 5708 Greenlawn Drive	
3. NAME OF DECEASED (Type or print) First Alcy Middle J. Last McCracken		4. DATE OF DEATH Month March Day 12 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 3, 1910
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elbert Perry		14. MOTHER'S MAIDEN NAME Fannie Shoup	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Joe B. McCracken, Husband		Address 5708 Greenlawn Drive Bethesda, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of the Liver 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Adenocarcinoma left breast DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 3 months 1 year
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 31, 1956 to March 12, 1958 , that I last saw the deceased alive on March 11, 1958 , and that death occurred at 12:35 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert G. Angle		ADDRESS (Street, city or town, state) 5009 Del Ray Ave, Bethesda	
PHYSICIAN'S NAME (Type) Robert G. Angle, M.D.		DATE SIGNED 3/12/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/15/58	22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery
22d. LOCATION (City, town, or county) Rockville, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR MAR 14 '58		24b. REGISTRAR'S SIGNATURE Quinn Smith	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 14 1958

BUREAU V. 5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 12, Film G227, 4/11/58
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

03549

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>83x-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mapel Lane Nursing Home</u>		d. STREET ADDRESS <u>1545 S. Vermont Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>SUSIE</u> Middle <u>McDERMOTT</u> Last <u>McDERMOTT</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>19</u> Year <u>1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 18, 1869</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Wallace</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Jane McCartney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Emma Baynes</u>		Address <u>1327 29th St. S. E. Wash, D. C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSIVE HEART DISEASE</u> DUE TO (c) <u>ESSENTIAL HYPERTENSION</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GENERALIZED ARTERIOSCLEROSIS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>OCT 2</u> , 19 <u>57</u> , to <u>MARCH 19</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>MARCH 19</u> , 19 <u>58</u> , and that death occurred at <u>435</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry H. Lowden</u> M.D.		ADDRESS (Street, city or town, state) <u>5206 N. Main St. D.C.</u>	
DATE SIGNED <u>3/19/58</u>			
PHYSICIAN'S NAME (Type) <u>HENRY H. LOWDEN</u>		<u>Cheng Chao-hed</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>& shipment</u>		22b. DATE THEREOF <u>March 22, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick's</u>		22d. LOCATION (City, town, or county) (State) <u>Lockport, N. Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. P. Jones</u>		ADDRESS <u>2847 Wilson Blvd., Arlington Va.</u>	
24a. REC'D BY REGISTRAR <u>MAR 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03550

3577

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>47X-3</u> b. COUNTY <u>WASHINGTON, D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON, D.C.</u>			
c. LENGTH OF STAY IN 1b <u>41 DAYS</u>				d. STREET ADDRESS <u>3421 McPlesant St NW</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAPLE LAKE NURSING HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARGARET E</u> Middle <u>MCDONNELL</u> Last <u>MCDONNELL</u>			4. DATE OF DEATH Month <u>MARCH</u> Day <u>24</u> Year <u>1958</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 9 1873</u> 55 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years lost by day) <u>55</u> yrs.		IF UNDER 1 YEAR: Months <u>24</u> Days <u>24</u> Hours <u>19</u> Min.	
11. BIRTHPLACE (State or foreign country) <u>New Orleans, LA.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Thomas Burnes</u>				14. MOTHER'S MAIDEN NAME <u>Pauline Burcher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>624 So. Taylor St ARLINGTON VA.</u>			
17. INFORMANT <u>N.W. McDONALD</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPERTENSIVE HEART DISEASE</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIO SCLEROSIS</u> DUE TO (c) <u>ESSENTIAL HYPERTENSION</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>FEB. 10</u> , 19 <u>58</u> , to <u>MARCH 24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>MARCH 24</u> , 19 <u>58</u> , and that death occurred at <u>1:55 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry M. Louden</u> M.D.				ADDRESS (Street, city or town, state) <u>5206 VERWAY DR. ARLINGTON VA.</u>			
DATE SIGNED <u>3/24/58</u>							
PHYSICIAN'S NAME (Type) <u>HENRY M. LOUDEN</u>				CHEVY CHASE, MD <u>3/24/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>3/28/58</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>CARROLTON</u>		22d. LOCATION (City, town, or county) (State) <u>New Orleans, LA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Reardon Co.</u> ADDRESS <u>300-4 St NE WASH DC</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 28 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Authentic</u>	

CERTIFICATE OF DEATH

1933

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>		DATE OF BIRTH <i>Jan 15 1888</i>		PLACE OF BIRTH <i>Baltimore, Md.</i>	
OCCUPATION <i>Teacher</i>		EDUCATION <i>High School</i>		MARRIAGE <i>Married</i>		SPOUSE <i>John Doe</i>		DATE OF MARRIAGE <i>Jan 15 1910</i>		PLACE OF MARRIAGE <i>Baltimore, Md.</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		DATE OF DEATH <i>Mar 10 1933</i>		PLACE OF DEATH <i>Baltimore, Md.</i>		TIME OF DEATH <i>10:00 AM</i>		SIGNATURE OF DECEASED <i>John Doe</i>	
SIGNATURE OF PHYSICIAN <i>John Doe</i>		DATE <i>Mar 10 1933</i>		SIGNATURE OF WITNESS <i>John Doe</i>		DATE <i>Mar 10 1933</i>		SIGNATURE OF DECEASED <i>John Doe</i>		DATE <i>Mar 10 1933</i>	
SIGNATURE OF DECEASED <i>John Doe</i>		DATE <i>Mar 10 1933</i>		SIGNATURE OF DECEASED <i>John Doe</i>		DATE <i>Mar 10 1933</i>		SIGNATURE OF DECEASED <i>John Doe</i>		DATE <i>Mar 10 1933</i>	

BUREAU V. S.

MAR 28 1933

RECEIVED

3578

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Mont.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 11 mos. 7 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Catharine Middle Norman Last MC FARLANE				4. DATE OF DEATH Month March Day 19 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 28 Oct. 1929	
9. AGE (In years last birthday) 28 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Texas	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Oliver LeGrand NORMAN				14. MOTHER'S MAIDEN NAME Sara Delia WARDEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address (Same As #2) (Husband) William D. MC FARLANE, JR.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ependymoma of Curved Spinal Cord 193.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Unknown							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from 26 March , 19 57 , to 19 March , 19 58 , that I last saw the deceased alive on 19 March , 19 58 , and that death occurred at 10:25 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE John W. Troy M.D. U.S. Naval Hospital, Bethesda, Md. 3-19-58 PHYSICIAN'S NAME (Type) John W. Troy, LCDR, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-21-58		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.				24a. REC'D BY REGISTRAR MAR 21 '58		24b. REGISTRAR'S SIGNATURE W. E. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with fields for Name, Age, Sex, Race, Date of Birth, Date of Death, Cause of Death, and other medical details. The text is mostly illegible due to the quality of the scan.

BUREAU V. S.

MAR 21 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 215

03552

3579

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 1 Day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Donna Middle Lynn Last MC GRATH				4. DATE OF DEATH Month March Day 27 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 24 Sept. 1950	
9. AGE (In years last birthday) 7 yrs.		IF UNDER 1 YEAR Months 7 Days 27 Hours 19 Min. 58		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) New York				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Lawrence John MC GRATH				14. MOTHER'S MAIDEN NAME Helen Rose HERMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (Father) Lawrence J. MC GRATH (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction DUE TO 587.3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fibrocystic Disease, pancreas + lungs DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) INTERVAL BETWEEN ONSET AND DEATH 2 days 7 yrs.							
21. I certify that I attended the deceased from 26 March , 19 58 , to 27 March , 19 58 , that I last saw the deceased alive on 27 March , 19 58 , and that death occurred at 8:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Burt C. Johnson M.D. U.S. Naval Hospital, Bethesda, Md. 3-28-58 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Burt C. Johnson, LCDR, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-1-58		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey				ADDRESS 255 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR APR 3 '58	
24b. REGISTRAR'S SIGNATURE W. H. Smith							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO. 10

NAME OF DECEASED J. J. J. J.		SEX M	
AGE 100		DATE OF BIRTH 1890	
PLACE OF BIRTH Maryland		CITY OF BIRTH Baltimore	
OCCUPATION None		EDUCATION None	
CAUSE OF DEATH None		MANNER OF DEATH None	
DATE OF DEATH 1930		PLACE OF DEATH None	
SIGNATURE OF DECEASED None		SIGNATURE OF WITNESS None	
SIGNATURE OF PHYSICIAN None		SIGNATURE OF CLERK None	
SIGNATURE OF JURY None		SIGNATURE OF JUDGE None	
SIGNATURE OF SHERIFF None		SIGNATURE OF CORONER None	
SIGNATURE OF DISTRICT ATTORNEY None		SIGNATURE OF COUNTY CLERK None	
SIGNATURE OF STATE CLERK None		SIGNATURE OF STATE ATTORNEY None	
SIGNATURE OF STATE DEPARTMENT OF HEALTH None		SIGNATURE OF STATE DEPARTMENT OF HEALTH None	

BUREAU V. 5

APR 3 1930

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03553

3580

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 9 Hr. 45 min.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Leo MC HUGH		4. DATE OF DEATH March 13 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 29 Sept. 1937
9. AGE (In years last birthday) 20 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corps	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Philip MC HUGH		14. MOTHER'S MAIDEN NAME Ellen Bertha THOMPSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes - Currently		16. SOCIAL SECURITY NO. 189 30 0935	
17. INFORMANT (Mother) Mrs. Ellen B. MC HUGH (Same As #2)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage and Laceration 919.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bullet wound through skull DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) sustaining injury INTERVAL BETWEEN ONSET AND DEATH 9 Hr. 45 min			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Playing with loaded pistol, unintentionally discharged	
20c. TIME OF INJURY 6:45 Hour March 12 1958 Month, Day, Year	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Navy Gun Factory	20f. (City or town) Washington, D. C. (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED 3-14-58	
EXAMINER'S NAME (Type) Frank J. Broschart, MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-17-58	22c. NAME OF CEMETERY OR CREMATORY Nat'l Cemetery	22d. LOCATION (City, town, or county) Beverly, New Jersey (State)
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers, 1400 Chapin St., Washington, D.C.		24a. REC'D BY REGISTRAR MAR 17 '58 24b. REGISTRAR'S SIGNATURE Overman	

FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: _____
2. Sex: _____
3. Age: _____
4. Date of Birth: _____
5. Place of Birth: _____
6. Usual Residence: _____
7. Date of Death: _____
8. Place of Death: _____
9. Cause of Death: _____
10. Manner of Death: _____
11. Signature of Medical Examiner: _____
12. Date of Examination: _____

BURMAN V. B.

MAR 17 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **03554**

3581

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>D.O.A</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Bethesda</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Surban</u>				/d. STREET ADDRESS <u>8202 Kentbury Dr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>T. Mc Kinlay</u> Last				4. DATE OF DEATH Month; <u>45</u> Day. Year <u>1958</u> <u>March 6</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 13, 1908</u>		9. AGE (In years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>Chicago, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Robert W. Mc Kinlay</u>				14. MOTHER'S MAIDEN NAME <u>Ethel Todd</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes (Navy) World War II</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Wife (Same as above)</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> 973.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carbon monoxide poisoning</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in auto</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Have attached to external injury into auto</u>					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/10/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 12 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. B.

MAR 12 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03555

3582

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE W. Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON				c. LENGTH OF STAY IN 1b 85-X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON GARDENS SANITARIUM				d. STREET ADDRESS Wheeling			
3. NAME OF DECEASED (Type or print) First KATHERINE Middle Last McLEAN				4. DATE OF DEATH Month MARCH Day 15 Year 1958			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-30-1870	
9. AGE (In years last birthday) yrs. 87		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) W. Virginia				12. CITIZEN OF WHAT COUNTRY? U.S. A.			
13. FATHER'S NAME John McLain				14. MOTHER'S MAIDEN NAME Margaret Hay			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Hosp. Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA PANCREAS 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio Sclerotic Heart INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 13, 1958 to March 13, 1958 , that I last saw the deceased alive on March 13, 1958 , and that death occurred at 3:17 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles M. Weber M.D.				ADDRESS (Street, city or town, state) 12600 PARKLAND Drive ROCKVILLE Md			
PHYSICIAN'S NAME (Type) Charles M. Weber				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 3-16-58		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Wheeling, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Bowler's Sons Inc.				ADDRESS 1756 Pa. Ave., N.W., DC		24a. REC'D BY REGISTRAR DATE MAR 18 '58	
				24b. REGISTRAR'S SIGNATURE W. Va.			

CERTIFICATE OF DEATH

18-5

NAME OF DECEASED MARY ANN M. M. M.		SEX FEMALE		AGE 60	
PLACE OF BIRTH BALTIMORE, MARYLAND		DATE OF BIRTH MARCH 15, 1898		PLACE OF DEATH BALTIMORE, MARYLAND	
OCCUPATION HOUSEWIFE		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
DATE OF DEATH MARCH 18, 1958		TIME OF DEATH 10:30 A.M.		PLACE OF INTERMENT GREENWICH CEMETERY	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES J. J. J. J. J.		SIGNATURE OF PHYSICIAN J. J. J. J. J.	
SIGNATURE OF REGISTRAR J. J. J. J. J.		SIGNATURE OF CLERK J. J. J. J. J.		SIGNATURE OF JURY J. J. J. J. J.	

BUREAU V. S.

MAR 18 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3583 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03556

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>Md.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1812 Cody Dr.</u>		d. STREET ADDRESS <u>1812 Cody Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>William John McMahon</u>		4. DATE OF DEATH Month <u>March</u> Day <u>17</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/4/75</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Floor mgr. (retired)</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Woodward & Lothrop</u>	
13. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		14. CITIZEN OF WHAT COUNTRY <u>USA</u>	
15. FATHER'S NAME <u>William McMahon</u>		16. MOTHER'S MAIDEN NAME <u>Mary (unknown)</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		18. SOCIAL SECURITY NO. <u>577-09-4587A</u>	
19. INFORMANT <u>Mrs. Zelda Mintzell, 1812 Cody Dr.</u>		20. ADDRESS <u>Silver Spring, Maryland</u>	
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u> Found dead in bed			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
22a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
23a. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		23b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
23c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		23d. (City or town) (County) (State)	
24. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		DATE SIGNED <u>March 17, 1958</u>	
25a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		25b. DATE THEREOF <u>3/20/58</u>	
25c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>		25d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
26. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
26a. REC'D BY REGISTRAR <u> </u>		26b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>MAR 20 '58</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FURNITURE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12
323 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male	
3. AGE 35		4. OCCUPATION None	
5. PLACE OF BIRTH Missouri		6. DATE OF BIRTH March 17, 1923	
7. MARITAL STATUS Single		8. EDUCATION High School	
9. RELIGION Catholic		10. RACE White	
11. SOCIAL SECURITY NUMBER 1-175		12. DATE OF DEATH April 4, 1968	
13. PLACE OF DEATH Baltimore, Maryland		14. CAUSE OF DEATH Suicide by gunshot	
15. MANNER OF DEATH Homicide		16. SIGNATURE OF EXAMINER [Signature]	
17. SIGNATURE OF WITNESS [Signature]		18. SIGNATURE OF CORONER [Signature]	

RECEIVED
MAR 20 1968
BUREAU X 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3584

CERTIFICATE OF DEATH

Reg. Dist. No.

03557

1. PLACE OF DEATH a. COUNTY Mont.		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md.		c. LENGTH OF STAY IN 1b 4 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Mont.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 8417 Dixon Ave., Silver Spring, Md.		d. STREET ADDRESS 8417 Dixon Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Harry Roy Mealey		4. DATE OF DEATH Month March Day 19 Year 1958		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 14, 1900		9. AGE (In years last birthday) 57 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus operator-Retired		11. BIRTHPLACE (State or foreign country) Frederick, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles E. Mealey		14. MOTHER'S MAIDEN NAME Effie Kolb		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-10-5363		17. INFORMANT Mrs. Sarah E. Mealey, 8417 Dixon Ave. Sil. Sp. Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe Secondary Anemia DUE TO (c) Chronic Lymphatic Leukemia		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 6 mos 2 years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Aug 12, 1957 , to Present , 19 58 , that I last saw the deceased alive on Feb-29, 1958 , and that death occurred at 12:20 PM , from the causes and on the date stated above.		ACTUAL SIGNATURE Merrill M. Cross		ADDRESS (Street, city or town, state) 8248 Morgan Ave. Silver Spring, Md.		DATE SIGNED 3/19/58		PHYSICIAN'S NAME (Type) Merrill M. Cross		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/22/58		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Wesley E. Humphrey		ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR MAR 24 '58		24b. REGISTRAR'S SIGNATURE W. E. Leach		24c. DATE		24d. DATE		24e. DATE		24f. DATE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE

LAST NAME

FIRST NAME

MIDDLE NAME

AGE

SEX

RACE

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

DATE OF BURIAL

PLACE OF BURIAL

NAME OF BURIAL PLACE

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

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BUREAU V. 81

MAR 24 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03558

3472

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <u>College Park</u> <u>1614.2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>				d. STREET ADDRESS <u>4619 College Avenue</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Moore</u>				4. DATE OF DEATH Month Day Year <u>March 4, 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-3-58</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Mins.		IF UNDER 24 HRS. Months Days Hours Mins.		10. AGE (In years last birthday) yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Perry Clay Moore</u>				14. MOTHER'S MAIDEN NAME <u>Peggy Jo Stone</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother</u>		Address <u>As above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>762.0</u> DUE TO <u>Congenital atelectasis Rt lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March 4, 1958</u> , to <u>March 4, 1958</u> , that I last saw the deceased alive on <u>March 4, 1958</u> , and that death occurred at <u>6:30 p.m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>8224 Georgia Avenue, Silver Spring, Md.</u> <u>3-4-58</u> ACTUAL SIGNATURE <u>H. H. Diamond</u> M.D. <u>H. H. Diamond, M.D.</u> PHYSICIAN'S NAME (Type) <u>8224 Georgia Avenue, Silver Spring, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>3-5-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington San. & Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Takoma Park, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Howe M.D.</u>				ADDRESS <u>Washington San. & Hospital</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 7 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Alfred Leach</u>							

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03559

CERTIFICATE OF DEATH

3585

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>1 hr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Moore</u> Last <u>Moore</u>		4. DATE OF DEATH Month <u>March</u> Day <u>22</u> Year <u>19 58</u>	
5. SEX <u>unknown</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/22/58</u>
9. AGE (In years last birthday) yrs. <u>57</u>		10. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Robert Moore</u>		14. MOTHER'S MAIDEN NAME <u>Edna Mae Reed</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Edna Mae Reed</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>759.3 Congenital deformity</u> DUE TO (b) <u>Absent abdominal wall</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Incomplete development lower spine</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>10:05 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>3/22/58</u> ACTUAL SIGNATURE <u>Richard A. Yates</u> M.D. PHYSICIAN'S NAME (Type) <u>R. A. Yates, M.D.</u> <u>Olney, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/23/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Presbyterian</u>	22d. LOCATION (City, town, or county) (State) <u>Olney, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Constance C. Hilton</u>		24. REG'D BY REGISTRAR <u>W. H. H. H.</u>	
ADDRESS <u>Barnesville</u>		DATE <u>MAR 20 58</u>	

2073222 XVV

RECEIVED

MAR 26 1958

BUREAU V. S.

BUREAU V. S.

MAR 26 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3586 CERTIFICATE OF DEATH

Reg. Dist. No.

03560

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring (Forest Glen)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X (Forest Glen) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Holman Avenue and Hale Place		d. STREET ADDRESS Holman Avenue and Hale Place	
3. NAME OF DECEASED (Type or print) Winifred Catherine Morris		4. DATE OF DEATH Month March Day 27 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/24/81
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Grey		14. MOTHER'S MAIDEN NAME Ann Crowder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Winifred G. Blume, 105 E. 37th St.		Address New York, N.Y.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive and arteriosclerotic cardio-vascular renal disease DUE TO (c) vascular renal disease		INTERVAL BETWEEN ONSET AND DEATH 1 month several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malnutrition		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 12, 1958 to 3-26, 1958 , that I last saw the deceased alive on 3-26, 1958 , and that death occurred at 12:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Forest Glen, Maryland DATE SIGNED 3-27-58			
ACTUAL SIGNATURE Jason Geiger		M.D. 931 Pershing Drive, Silver Spring, Md.	
PHYSICIAN'S NAME (Type) Jason Geiger			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/29/58	
22c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		22d. LOCATION (City, town, or county) (State) Forest Glen, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		24. REC'D BY REGISTRAR Silver Spring, Md.	
24a. DATE MAR 31 '58		24b. REGISTRAR'S SIGNATURE Reese	

CERTIFICATE OF DEATH

REGISTRATION

NAME OF DECEASED: [Faint text]

DATE OF DEATH: [Faint text]

PLACE OF DEATH: [Faint text]

CAUSE OF DEATH: [Faint text]

DATE OF BIRTH: [Faint text]

PLACE OF BIRTH: [Faint text]

DATE OF DEATH: [Faint text]

PLACE OF DEATH: [Faint text]

CAUSE OF DEATH: [Faint text]

DATE OF BIRTH: [Faint text]

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CAUSE OF DEATH: [Faint text]

DATE OF BIRTH: [Faint text]

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CAUSE OF DEATH: [Faint text]

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CAUSE OF DEATH: [Faint text]

DATE OF BIRTH: [Faint text]

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DATE OF DEATH: [Faint text]

PLACE OF DEATH: [Faint text]

BUREAU V. E.

MAR 31 1958

RECEIVED

3587

CERTIFICATE OF DEATH

03561

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centerville 17X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		d. STREET ADDRESS RFD #3	
3. NAME OF DECEASED (Type or print) First George Middle Foster Last MURDOCH		4. DATE OF DEATH Month March Day 19 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 Feb. 1931
9. AGE (In years last birthday) 27 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming & Floristry		10b. KIND OF BUSINESS OR INDUSTRY Commercial	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Bruce MURDOCH		14. MOTHER'S MAIDEN NAME Ruth FOSTER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 215 36 1359	
17. INFORMANT (Mother) Mrs. Ruth F. Murdoch (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 200.1 IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) Disseminated Lymphosarcoma PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 years		INTERVAL BETWEEN ONSET AND DEATH 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 17 March , 19 58 , to 19 March , 19 58 , that I last saw the deceased alive on 18 March , 19 58 , and that death occurred at 3:40 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE T.S. Dunn, Jr.		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) T.S. DUNN, JR., LT, MC, USN		DATE SIGNED 3-19-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-21-58	
22c. NAME OF CEMETERY OR CREMATORY Centerville, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE S. H. HINES CO., WASHINGTON, D. C.		24a. REC'D BY REGISTRAR DATE MAR 21 '58	
24b. REGISTRAR'S SIGNATURE Barton Funeral Home, Centerville, Maryland			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARKYARD STATE DEPARTMENT OF HEALTH - BIRMINGHAM 18

FILE NO.

DATE OF DEATH

(1958)

U.S. SOCIAL SECURITY NUMBER

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

INDUSTRY

CAUSE OF DEATH

DIAGNOSIS

DATE OF EXAMINATION

EXAMINER

REPORT

REMARKS

SIGNATURE

DATE

PLACE

STATE

CITY

BUREAU V. S.

MAR 21 1958

RECEIVED

3588

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Connecticut b. COUNTY Wallingford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 53 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. STREET ADDRESS 63 Simpson Avenue			
3. NAME OF DECEASED (Type or print) First Lela Middle Gracie Last Myers				4. DATE OF DEATH Month March Day 7 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 18, 1894		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months 45 Days X Hours 3 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Connecticut		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Eugene Beach				14. MOTHER'S MAIDEN NAME Ellen Gracie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unascertainable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Staphylococcal Septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Staphylococcal Peritonitis and Pneumonia DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Cervix; Stomach Ulceration						INTERVAL BETWEEN ONSET AND DEATH 2 wks 3 wks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from January 13, 1958 , to March 7, 1958 , that I last saw the deceased alive on March 7, 1958 , and that death occurred at 11:50 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert B. Couch				ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 3-8-58	
PHYSICIAN'S NAME (Type) Robert B. Couch, M. D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit		22b. DATE THEREOF 3/8/58		22c. NAME OF CEMETERY OR CREMATORY In Memoriam		22d. LOCATION (City, town, or county) (State) Wallingford, Conn.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE MAR 12 '58		24b. REGISTRAR'S SIGNATURE Alfred	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 12 1958-

RECEIVED

3589

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Marys.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Piney Point</u>		188-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>John</u> Last <u>Newland</u>				4. DATE OF DEATH Month <u>3</u> Day <u>14</u> Year <u>1958</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 11, 1895</u>		9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>14</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plate Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bureau of Engraving</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph Newland</u>				14. MOTHER'S MAIDEN NAME <u>Auna Dorr</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>Army</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Virginia M. Edwards</u> Address <u>12412 Persimmon Rd. Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction, left ventricle</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Thrombosis, left circumflex coronary art.</u> 4 days (c) <u>Coronary sclerosis</u> years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Superior mesenteric artery thrombosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1954</u> , 19 to <u>3/14</u> , 1958 that I last saw the deceased alive on <u>3/13/58</u> , 19 and that death occurred at <u>3/14</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>900-17th St. S.W.</u> DATE SIGNED							
ACTUAL SIGNATURE <u>Edward Newland</u> M.D.				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-18-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u> ADDRESS <u>Washington D.C.</u>				24a. REC'D BY REGISTRAR <u>MAR 19 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

MAR 19 1958

RECEIVED

Francis G. Collins Washington D.C.

3473

CERTIFICATE OF DEATH

03564

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sen + Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Springs</u> d. STREET ADDRESS <u>112105 Bluff Hill Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ALLEN</u> First <u>JAY</u> Middle <u>Newby</u> Last 4. DATE OF DEATH Month <u>March</u> Day <u>5</u> Year <u>1958</u>				5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Nov. 11, 1902</u> 9. AGE (In years last birthday) <u>55</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Upholsterer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Upholstery</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William H. Newby</u>				14. MOTHER'S MAIDEN NAME <u>CARRIE Kennedy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>241-07-0723</u>		17. INFORMANT <u>Bertha Maye Newby</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pancreatitis</u> <u>587.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 3, 1958</u> , to <u>March 5, 1958</u> , that I last saw the deceased alive on <u>March 5, 1958</u> , and that death occurred at <u>2:25 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6480 New Hampshire Ave Takoma Park, Md.</u> DATE SIGNED <u>3/5/58</u> ACTUAL SIGNATURE <u>Norman H. Rubenstein</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Takoma Park, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		22b. DATE THEREOF <u>3/6/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove Methodist Ch. Cem. Thomasville, N.C.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>2901 Adams St. N.W. The S.H. Hines Co. Washington 9, D.C.</u>				24a. REC'D BY REGISTRAR <u>MAR 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Quelovich</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

• **CHLORIDE** (CL) •

MAR 7 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3590

Reg. Dist. No. 03565

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resmor Sanitarium & Hospital</u>				d. STREET ADDRESS <u>6029 Berkshire Dr.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Teresa</u> Middle <u>M</u> Last <u>O'Brien</u>				4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>Wh</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 16, 1893</u>	
9. AGE (In years lost birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min.		IF UNDER 24 HRS. Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Edwin Moor</u>				14. MOTHER'S MAIDEN NAME <u>Mildred Lynn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Mrs. Katherine Berens</u>				Address <u>daughter DR. 6029 Berkshire</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senescence</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. 11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>—</u>				20g. (County) <u>—</u>		20h. (State) <u>—</u>	
21. I certify that I attended the deceased from <u>Nov.</u> , 19 <u>57</u> , to <u>Mar.</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Mar.</u> , 19 <u>58</u> , and that death occurred at <u>2:40 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wilfred R. Ehrmantraut</u> M.D.				ADDRESS (Street, city or town, state) <u>4890 Battery Lane, Bethesda, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Wilfred R. Ehrmantraut MD</u>				DATE SIGNED <u>3/1/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/4/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>—</u>	
24b. REGISTRAR'S SIGNATURE <u>—</u>				DATE <u>MAR 5 '58</u>			

BUREAU V. S.

MAR 5 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **03566**

3591

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 4 yrs	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE md		b. COUNTY montg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 115 ST. LAWRENCE DR.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Andrew Joseph O'Neill		4. DATE OF DEATH Mar 10 1958		5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH Jan 31 1886		9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY Spencer's War Dept.		11. BIRTHPLACE (State or foreign country) Wash. DC		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Andrew O'Neill		14. MOTHER'S MAIDEN NAME Jane A. Connor		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Anna A O'Neill (sister)		Address Same Street 2		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE: (a) Coronary occlusion 420.1 DUE TO (b) hypertension Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) 4 yrs		INTERVAL BETWEEN ONSET AND DEATH sudden		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE Frank J. Breschait M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Mar 10 58		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/13/58		22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D. C.		23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR Mar 12 '58		24b. REGISTRAR'S SIGNATURE Outreach	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 1

MAR 12 1959

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3592

CERTIFICATE OF DEATH

03567

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>14 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>1629 Sligo Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Hallie</u> Middle <u>N.</u> Last <u>Pearre</u>				4. DATE OF DEATH Month <u>March</u> Day <u>21</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-20-1878</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>no</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Unionville, Maryland</u>	
13. FATHER'S NAME <u>George D. Norris</u>				14. MOTHER'S MAIDEN NAME <u>Olivia Warner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs. Henry Moler</u> Address <u>629 Sligo Ave. Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio sclerotic cardiovascular disease</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>DUE TO</u> (c) <u>Acute cholecystitis</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 YEARS</u> <u>2 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X DIABETES MELLITUS. YEARS.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>MAR</u> <u>1957</u> , to <u>MAR 21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>MAR 21</u> , 19 <u>58</u> , and that death occurred at <u>1450 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Delwitt E. DeLauter</u>				ADDRESS (Street, city or town, state) <u>8025 ARDEN RD Bethesda Md</u>			
PHYSICIAN'S NAME (Type) <u>Delwitt E. DeLauter</u>				DATE SIGNED <u>3/21/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-25-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WINGANORE</u>		22d. LOCATION (City, town, or county) (State) <u>Fredrick Co, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz</u> ADDRESS <u>Wixfield, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

EX-101 (Rev. 1-1-38)

BUREAU V. 3

MAR 26 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **03568**

3593

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN lb <u>12 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>126 Lee St</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u> d. STREET ADDRESS <u>126 Lee St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Wilson Davis Perry</u> First Middle Last				4. DATE OF DEATH <u>Mar. 22, 1958</u> Month Day Year									
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>11/20/37</u> <u>28</u> yrs.		9. AGE (In years last birthday) <u>20</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maintenance Service Company</u>				11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Woodrow W. Perry</u>						14. MOTHER'S MAIDEN NAME <u>Minnie Pearl Davis</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>240-62-1223</u>				17. INFORMANT Address <u>Montg. CO. Police, Silver Spring, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subdural Hemorrhage</u> 900.0 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture of skull</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> <u>6 hrs</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down stairs at friends home</u>									
20c. TIME OF INJURY Month, Day, Year <u>1:30</u> a. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>				20f. (City or town) (County) (State) <u>Silver Spring Montg. Md.</u>			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>Frank J. Broschart</u> EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Mar. 22, 1958</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3/23/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bula Christian Church Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Wake Forest, N. C.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>						ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 24 '58</u> DATE		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

130

BUREAU V. S.

MAR 24 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 03569

3474

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hosp.</u>		d. STREET ADDRESS <u>1226 Noyes Drive</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert Leo Petzold</u>		4. DATE OF DEATH Month Day Year <u>March 2 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 12, 1890</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant, Internal Revenue</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Gov't.</u>	
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Moritz Petzold</u>		14. MOTHER'S MAIDEN NAME <u>KATHERINE SCHLOSSER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> YES <input type="checkbox"/> WW #1 <u>1</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT Address <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Oxytocin</u> 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>chronic pyelonephritis</u> DUE TO (c) <u>concurrent of Waddell + prostate</u> 10 days azotemia 1 1/2 yrs			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/15</u> , 19 <u>58</u> , to <u>3/2</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/1</u> , 19 <u>58</u> , and that death occurred at <u>8:02 A</u> .M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Arthur J. Wilets</u> M.D.			
PHYSICIAN'S NAME (Type) <u>ARTHUR J. WILETS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3/4/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 6 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur J. Wilets</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No 215

03570

3594

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 81 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Massachusetts b. COUNTY Holyoke		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NMMC, Bethesda Md.		d. STREET ADDRESS 22 Newton Place							
3. NAME OF DECEASED (Type or print) Gerald		First George		Middle PICARD		Last		4. DATE OF DEATH Month March Day 2 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 25 February 1918		9. AGE (In years last birthday) 40 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreign Service Officer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME George PICARD		14. MOTHER'S MAIDEN NAME Anna LAJENESSE							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. unknown		17. INFORMANT (Official Navy Records)		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASTROCYTOMA, FIBRILLARY, BT. FRONTAL lobe 193.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH UNDETERMINED							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Jacksonville		(County) (State)	
21. I certify that I attended the deceased from 11 December, 1957 , to 2 March , 19 58 , that I last saw the deceased alive on 2 March , 19 58 , and that death occurred at 6:18A M, from the causes and on the date stated above.									
ACTUAL SIGNATURE John W. Troy		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md.		DATE SIGNED 3-3-58					
PHYSICIAN'S NAME (Type) JOHN W. TROY, LCDR, MC, USN		U.S. Naval Hospital, Bethesda Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-7-58		22c. NAME OF CEMETERY OR CREMATORY Riverside Memorial Park		22d. LOCATION (City, town, or county) Jacksonville		(State) Florida	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey		ADDRESS Cemetery		24e. RECD BY REGISTRAR MAR 5 '58		24b. REGISTRAR'S SIGNATURE Alfred			

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 5. 1938

BUREAU V. E.

(RECEIVED)

3595
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>21 mo.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				d. STREET ADDRESS <u>1 Willow Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Mabel</u> Middle <u>A.</u> Last <u>Plummer</u>				4. DATE OF DEATH Month <u>March</u> Day <u>7</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 12, 1874</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Practical Nursing</u>		11. BIRTHPLACE (State or foreign country) <u>Minnesota</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>George M. Plummer</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Crystal</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Hospital records</u>			
17. INFORMANT Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>(1) Myocarditis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Congestion</u> DUE TO (c) <u>Arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>3-6-</u> , 19 <u>58</u> , to <u>3-7-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3-6-</u> , 19 <u>58</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) <u>[Address]</u>			
PHYSICIAN'S NAME (Type) <u>[Signature]</u>				M.D. <u>[Signature]</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 10, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				ADDRESS <u>254 Carroll St NW</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 10 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 10 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3596

CERTIFICATE OF DEATH

Reg. Dist. No.

03572

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 23 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3 ✓			
f. STREET ADDRESS 505 U Street, N. W.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle (none) Last Pooler				4. DATE OF DEATH Month March Day 20 Year 19 58			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 15, 1909	
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS. Days		12. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Interior Decorator				10b. KIND OF BUSINESS OR INDUSTRY Interior Decorating			
11. BIRTHPLACE (State or foreign country) South Carolina				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Lee Pooler				14. MOTHER'S MAIDEN NAME Frances Martin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Unascertainable			
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 5 days DUE TO (c) Hypertensive arteriosclerotic cardiovascular dis 17 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from February 25, 19 58 , to March 20, 19 58 , that I last saw the deceased alive on March 20, 19 58 , and that death occurred at 5:35 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE James C. Allen M.D.				ADDRESS (Street, city or town, state) The Clinical Center 3/21/58			
PHYSICIAN'S NAME (Type) James C. Allen, M.D.				DATE SIGNED 3/21/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3-26-58		22c. NAME OF CEMETERY OR CREMATORY Arlington	
22d. LOCATION (City, town, or county) Arlington				(State) D.C.			
23. FUNERAL DIRECTOR'S SIGNATURE R. L. Crouch ADDRESS 51 Kay St. N.W.				24a. REC'D BY REGISTRAR APR 7 '58		24b. REGISTRAR'S SIGNATURE W. H. Smith	

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for death certificate data, including fields for name, date, and cause of death. The text is mirrored and difficult to read.

BUREAU V. 3

APR 7 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3597

CERTIFICATE OF DEATH

Reg. Dist. No. 03573

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 19 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Raymond Middle Clayton Last Powers				4. DATE OF DEATH Month March Day 7 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 27, 1905	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman				10b. KIND OF BUSINESS OR INDUSTRY Merchant Marine		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Purvis Powers				14. MOTHER'S MAIDEN NAME Lelia Powers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 086-14-6052		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aortic Stenosis, Post Operative Valvulotomy 410X DUE TO Cardiac Arrest, Post Operative (b) Hypertrophy and Dilatation of Heart Cocgestion, Lungs, Severe (c) Cocgestion, Lungs, Severe							INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 16, 1958 , to March 7, 1958 , that I last saw the deceased alive on March 7, 1958 , and that death occurred at 8:58A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Carlos R. Lombardo M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 3/7/58			
PHYSICIAN'S NAME (Type) CARLOS R. LOMBARDO, M.D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		3-10-58		Meadowbrook		Lumberton N.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Pearson's Funeral Home				24. REC'D BY REGISTRAR Falls Church			
ADDRESS				24b. REGISTRAR'S SIGNATURE W. J. Leach			
				DATE MAR 10 '58			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 10 1953

RECEIVED

3598

CERTIFICATE OF DEATH

03574

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 9 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY District of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1916 17th Street, N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charles Washington Price, Jr.		4. DATE OF DEATH Month Day Year March 26 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 October 1889
9. AGE (In years last birthday) 68		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Detective		10b. KIND OF BUSINESS OR INDUSTRY Pinkerton's Agency	11. BIRTHPLACE (State or foreign country) New Jersey
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Charles W. Price, Sr.	
14. MOTHER'S MAIDEN NAME Lora Mount		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-I	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Official Navy Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation during Surgery 451X DUE TO Abdominal Aortic Aneurysm (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 17 March 19 58 to 26 March 19 58 , that I last saw the deceased alive on 26 March 19 58 , and that death occurred at 8:12 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert J. Cales		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) Robert J. Cales, LT, MC, USN		DATE SIGNED 3-28-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-31-58	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE S.H. HINES		24a. REC'D BY REGISTRAR MAR 31 '58	24b. REGISTRAR'S SIGNATURE Al. Search

Dr. Frank J. Broschart, MD. Notified. Hospital authorized to handle in usual manner.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

Form with multiple fields for death certificate information, including name, date, and location. The text is mostly illegible due to the quality of the scan.

BUREAU V. R.

MAR 31 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03575

Reg. Dist. No.

3482

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	c. LENGTH OF STAY IN lb <u>6 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1506 Grandin Ave</u>		d. STREET ADDRESS <u>1506 Grandin Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Charles William Price</u>		4. DATE OF DEATH <u>Mar 29 1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-26-11</u>
9. AGE (In years last birthday) <u>47 yrs.</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>3</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Army map service</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Govt.</u>	
11. BIRTHPLACE (State or foreign country) <u>Cal.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. C.</u>	
13. FATHER'S NAME <u>Charles Price</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>W. W. II</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>547-03-3266</u>	
17. INFORMANT <u>Elvira Price (wife)</u>		Address <u>Stim 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Cerebral occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> <u>Mar 29-1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/1/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md</u>		24a. REC'D BY REGISTRAR <u>Mar 31 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

3599

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Montg.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Southsburg</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Springs, (Rural)</i>			
c. LENGTH OF STAY IN 1b <i>8 1/2 mos</i>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Ammon's Rest Home</i>			
d. STREET ADDRESS <i>Rt. 7 D. # 2</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Ella</i> First <i>Pumphrey</i> Middle <i>Rose</i> Last				4. DATE OF DEATH <i>March 31</i> 19 <i>58</i> Month Day Year			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Colored</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept. 1, 1893</i>	
9. AGE (In years last birthday) <i>64</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Benjamin F. Thomas</i>				14. MOTHER'S MAIDEN NAME <i>Martha A. Holland</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <i>Florence L. Powell</i> Address <i>246 N. Wash. St. Rockville, Md.</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Embolism</i> <i>199.2</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma Metastasis</i> DUE TO (c) <i>Hepatic or Pelvic Carcinoma</i>							INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>1. Chronic Cholecystitis 2 Arthritis</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <i>19</i> Hour a. m. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>Feb 21, 1947</i> to <i>March 31, 1958</i> , that I last saw the deceased alive on <i>March 31, 1958</i> , and that death occurred at <i>8:15 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Webster Sewell</i> M.D.				ADDRESS (Street, city or town, state) <i>Rockville Rd 1</i> DATE SIGNED <i>4.4.58</i>			
PHYSICIAN'S NAME (Type) <i>WEBSTER SEWELL</i>				<i>Silver Spring, Md</i>			
22a. BURIAL, CREMATION, or other disposition (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/7/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i>		22d. LOCATION (City, town or county) (State) <i>Arlington, Va.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Sumner</i> ADDRESS <i>Rockville, Md.</i>				24a. REC'D BY REGISTRAR <i>APR 9 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Robert L. Sumner</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

3600

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>20 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Lanning</u> Last <u>Ray</u>				4. DATE OF DEATH Month <u>March</u> Day <u>23</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/13/92</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY? <u>R. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farm Manager</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>R. S. A.</u>			
13. FATHER'S NAME <u>George Franklin Ray</u>				14. MOTHER'S MAIDEN NAME <u>Alice Bogley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>217-36-6532</u>			
17. INFORMANT <u>Janie A Ray</u>				Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Failure</u> 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Diabetes Mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> <u>yrs</u> <u>yrs</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>3/22, 1958</u> , to <u>3/23, 1958</u> , that I last saw the deceased alive on <u>3/23, 1958</u> , and that death occurred at <u>10:45 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Charles Legion</u>				M.D. <u>Sandy Spring Md.</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-26-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Upper Seneca Baptist</u>		22d. LOCATION (City, town, or county) (State) <u>Cedar Grove, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray W Barber</u>				ADDRESS <u>Laytonsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>3-25-58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 5

MAR 31 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3671

CERTIFICATE OF DEATH

03577

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Germantown</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Marylander Rest Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lucy</u> Middle <u>T</u> Last <u>Reed</u>				4. DATE OF DEATH Month <u>March</u> Day <u>16</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 26, 1870</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>20</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>							
13. FATHER'S NAME <u>Lewis Thorp</u>				14. MOTHER'S MAIDEN NAME <u>Anna A. Wise</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>George N. Reed, same as 2d</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>							
DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u>							
DUE TO (c) <u></u>							
INTERVAL BETWEEN ONSET AND DEATH <u>7 days.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. g. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <u>2/22</u> , 19 <u>58</u> , to <u>March 16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>March 10</u> , 19 <u>58</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James P. Kerr</u>				ADDRESS (Street, city or town, state) <u>Damascus, Md.</u>		DATE SIGNED <u>3/16/58</u>	
PHYSICIAN'S NAME (Type) <u>James P. Kerr</u>				<u>Damascus, Maryland</u>		<u>3/16/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Trans.</u>		22b. DATE THEREOF <u>3/19/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Marietta, Ohio</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>W. J. [unclear]</u> DATE <u>3/18/58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. [unclear]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 03578

3602

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Olney</u>				c. LENGTH OF STAY IN 1b <u>2 yrs 3 mo</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove foundation</u>				e. STREET ADDRESS <u>1220 Dale Drive</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Louise</u> Last <u>Briegner</u>				4. DATE OF DEATH Month <u>March</u> Day <u>30</u> Year <u>19 58</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>vv</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-31-1877</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John School</u>				14. MOTHER'S MAIDEN NAME <u>Barbara (unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>1220 Dale Dr. Silver Sp</u> <u>Mrs Charles H. Briegner</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerosis</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Soft Hemiplegia</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 16 -</u> , 19 <u>56</u> , to <u>3-30 -</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3-23 -</u> , 19 <u>58</u> , and that death occurred at <u>540 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. W. Bird</u>				ADDRESS (Street, city or town, state) <u>Sandy Spring Md</u> DATE SIGNED <u>3/30/58</u>			
PHYSICIAN'S NAME (Type) <u>J. W. BIRD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/2/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Norland Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Chambersburg, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Humphrey</u> ADDRESS <u>Silver Spring, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 31 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Overman</u>	

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CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Form with fields for: NAME OF DECEASED, SEX, AGE, DATE OF BIRTH, PLACE OF BIRTH, OCCUPATION, CAUSE OF DEATH, etc.

Left 11:00 AM
11:00 AM

BUREAU V. E.

MAR 31 1958

RECEIVED

Form with fields for: SIGNATURE, DATE, and other administrative details.

3603

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport, Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>116 N Artizan St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Aurelia</u> Middle <u>Cecile</u> Last <u>Ritter</u>		4. DATE OF DEATH Month <u>March</u> Day <u>30</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/28/1899</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR: Months <u>10</u> Days <u>1</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Williamsport, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Darby Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Jessie Thompson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Daughter</u>		Address <u>5025 Rockwood Washington, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory and Cardiovascular failure</u> DUE TO <u>193.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Increased intracranial Pressure</u> DUE TO <u>Maligant Brain Tumor, post surgical</u> (c) <u>Reurrence of Bram Tumor</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u> <u>+</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 15, 1957</u> to <u>Mar 30, 1958</u> , that I last saw the deceased alive on <u>Mar 29, 1958</u> , and that death occurred at <u>9:45 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William P. Mustard</u>		ADDRESS (Street, city or town, state) <u>Washington Clinic, WASHINGTON 15, D.C.</u>	
DATE SIGNED <u>APR 1 1958</u>		M.D. <u>WASHINGTON CLINIC, WASHINGTON 15, D.C.</u>	
PHYSICIAN'S NAME (Type) <u>Albert P. Mustard</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/2/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Riverside Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Williamsport, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert P. Mustard</u>		24a. REC'D BY REGISTRAR <u>APR 1 1958</u>	
ADDRESS <u>Williamsport, Md</u>		24b. REGISTRAR'S SIGNATURE <u>W. P. Mustard</u>	

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CERTIFICATE OF DEATH

RECEIVED
BUREAU OF VITAL RECORDS
JAN 10 1958

BUREAU V. 5

APR 1 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3694

CERTIFICATE OF DEATH

Reg. Dist. No.

03589

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>11 yrs.</u>				d. STREET ADDRESS <u>720 Belvedere Blvd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>720 Belvedere Blvd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Wesley</u> Last <u>Robb Sr.</u>				4. DATE OF DEATH Month <u>March</u> Day <u>30</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/22/93</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>4</u> Hours <u>30</u> Min.		IF UNDER 24 HRS. Months <u>6</u> Days <u>4</u> Hours <u>30</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Automobile Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>		11. BIRTHPLACE (State or foreign country) <u>Creed, Colorado</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James Wesley Robb, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Thompson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW #1</u>				16. SOCIAL SECURITY NO. <u>577-03-6326</u>			
17. INFORMANT <u>Mrs. Clotilde D. Robb</u>				Address <u>720 Belvedere Blvd. Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>March 25, 1958</u> to <u>March 30, 1958</u> , that I last saw the deceased alive on <u>March 30, 1958</u> , and that death occurred at <u>6:30</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bennet A. Porter, Jr.</u>				ADDRESS (Street, city or town, state) <u>9301 Colesville Rd., Silver Spring, Md.</u>			
PHYSICIAN'S NAME (Type) <u>BENNET A. PORTER, JR.</u>				DATE SIGNED <u>March 30, 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/2/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>MAR 31 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>W. E. Smith</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

DATE OF DEATH

PLACE

CAUSE OF DEATH

AGE

SEX

DATE

CITY, STATE

CITY, STATE

NAME OF DECEASED

NAME OF DECEASED

NAME OF DECEASED

NAME OF DECEASED

BUREAU K. 1

MAR 31 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03581

3605

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3820 Washington Street		d. STREET ADDRESS 3820 Washington Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John Leonard ROBERTS			
4. DATE OF DEATH March 11 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 22, 1895
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR 6 Months 19 Days	IF UNDER 24 HRS. 19 Hours 58 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney-retired		10b. KIND OF BUSINESS OR INDUSTRY Legal	11. BIRTHPLACE (State or foreign country) Columbia, Tennessee
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Addison P. Roberts	
14. MOTHER'S MAIDEN NAME Lemyra Stanfeld		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) W. W. I	
16. SOCIAL SECURITY NO.		17. INFORMANT Minnie L. Roberts-Same Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) 420.1 (a), stating the underlying cause last. DUE TO (c) 420.1			
INTERVAL BETWEEN ONSET AND DEATH 10 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) History of previous heart attacks			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED March 12, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-14-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md		24a. REC'D BY REGISTRAR MAR 14 '58	
24b. REGISTRAR'S SIGNATURE W. H. Leach			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

14 1958

3606

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 12 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. STREET ADDRESS 111 N. Linwood Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Mary Middle Katherine Last Robl				4. DATE OF DEATH Month March Day 28 , Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 9, 1906	
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Michael Szymanski				14. MOTHER'S MAIDEN NAME Katherine Kantorski			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 3-28-10-1		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 173X Cardiac arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anoxia DUE TO (c) Chronic pneumonia metastatic to lungs							
INTERVAL BETWEEN ONSET AND DEATH 2 Several hrs. 1 month							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 16, 1958 , to March 28, 1958 , that I last saw the deceased alive on March 28, 1958 , and that death occurred at 6:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 3/28/58							
ACTUAL SIGNATURE Allen D. Goodman M.D.				PHYSICIAN'S NAME (Type) Allen D. Goodman, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4/1/58		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	
22d. LOCATION (City, town, or county) (State) Baltimore, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran-3000 E. Baltimore St.				24a. REC'D BY REGISTRAR DATE MAR 31 '58		24b. REGISTRAR'S SIGNATURE W. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03583

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Derwood	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Zion Nursing Home		d. STREET ADDRESS 229 Bryant St., N.E.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Linwood Guy Rolins		4. DATE OF DEATH Mar. 4, 1958	19
5. SEX male	6. COLOR OR RACE col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 76 yrs.
9. AGE (In years last birthday) 76		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Preacher		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Iassio Rolins	
14. MOTHER'S MAIDEN NAME Melissa Gray		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Nursing Home Record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure 163X DUE TO Conditions, if any, which gave rise to immediate cause (b) Carcinoma of lung (c), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH 3 hrs 6 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 3/4/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-9-58	
22c. NAME OF CEMETERY OR CREMATORY Bells Chapel		22d. LOCATION (City, town, or county) (State) Dickerson, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE R. L. Snowden, Rockville, Md.		24a. RECEIVED BY REGISTRAR MAR 12 58	
24b. REGISTRAR'S SIGNATURE Ch. Leach			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		JAN 15 1893		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		MILITARY SERVICE		PREVIOUS ILLNESS	
1234 E. BALTIMORE ST.		CLOCK REPAIRER		HIGH SCHOOL		MARRIED		NONE		NONE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		POST-MORTEM	
MAR 12 1939		HOME		HEART DISEASE		NATURAL		NONE		NONE	
SIGNATURE OF EXAMINER		TITLE		DATE		PLACE		HOSPITAL		LABORATORY	
J. H. HARRIS		M.D.		MAR 12 1939		BALTIMORE		BALTIMORE		BALTIMORE	

BUREAU V. S.

MAR 12 1939

RECEIVED

3678

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. (D.C.) b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 29 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 15	
		d. STREET ADDRESS 5415 Conn. Ave., N. W.	
3. NAME OF DECEASED (Type or print) First MABEL Middle MARGARET Last RONEMUS		4. DATE OF DEATH Month March Day 16th Year 19 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 7, 1890
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Peter J. Clarke		14. MOTHER'S MAIDEN NAME Dosia Melroy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none		16. SOCIAL SECURITY NO. none	
17. INFORMANT Leo W. Ronemus, 5415 Conn. Ave., Wash., DC		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease - 3 yrs.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MARCH 15, 1958 to MARCH 16, 1958 , that I last saw the deceased alive on MARCH 15, 1958 , and that death occurred at 12:50 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Leo M. Curtis M.D.		ADDRESS (Street, city or town, state) 8218 WISCONSIN AVE., BETHESDA 14, MD.	
PHYSICIAN'S NAME (Type) Leo M. Curtis		DATE SIGNED 3/16/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 18, 1958	
22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR MAR 18 '58	
		24b. REGISTRAR'S SIGNATURE Alfred	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

John Robert

Shelton Hospital

1000 W. MARGARET ST. BALTIMORE, MD.

Female White Age 65 Date of Birth May 1, 1890

Residence 1000 W. MARGARET ST. BALTIMORE, MD.

Physician Peter A. Clark

1000 W. MARGARET ST. BALTIMORE, MD.

BUREAU V. B.

MAR 18 1958

RECEIVED

3699

CERTIFICATE OF DEATH

Reg. Dist. No.

03586

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundelle</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>North Chevy Chase</i>		c. LENGTH OF STAY IN 1b <i>2 weeks</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>8908 Montgomery Ave.</i>		d. STREET ADDRESS <i>500 Fairfax Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>Ann Marie Rosinski</i>		4. DATE OF DEATH <i>Mar. 8 1958</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 29, 1875</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	9. AGE (In years last birthday) <i>82</i> yrs.
11. BIRTHPLACE (State or foreign country) <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Stanislaus Stetnick</i>		14. MOTHER'S MAIDEN NAME <i>Wilhelmina ?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Mario Reid</i>		Address <i>8908 Montgomery Ave North Chevy Chase</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> DUE TO <i>420.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral occlusion</i> DUE TO <i>10 hours</i> (c) <i>Arteriosclerotic heart disease</i> <i>15 years</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>260x Diabetic Mellitus</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>None</i> p. m. <i>None</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Mar. 7, 1958</i> , to <i>Mar. 8, 1958</i> , that I last saw the deceased alive on <i>Mar. 8, 1958</i> , and that death occurred at <i>11:30 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John B. Umhau</i> M.D.		ADDRESS (Street, city or town, state) <i>8805 CORN. AVE.</i> DATE SIGNED <i>3/8/58</i>	
PHYSICIAN'S NAME (Type) <i>JOHN B. UMAU</i>		<i>Cherry Chase 15 Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3/11/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St Marys</i>	22d. LOCATION (City, town, or county) (State) <i>Washington D.C.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frank Severe Sons Co</i>		ADDRESS <i>3605-14 St NW Wash D.C.</i>	
24a. REC'D BY REGISTRAR <i>—</i>		24b. REGISTRAR'S SIGNATURE <i>—</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

PLACE OF DEATH _____		COUNTY _____	
SEX _____		AGE _____	
OCCUPATION _____		MARITAL STATUS _____	
DATE OF DEATH _____		TIME OF DEATH _____	
PLACE OF BIRTH _____		DATE OF BIRTH _____	
NAME OF DECEASED _____		NAME OF FATHER _____	
NAME OF MOTHER _____		NAME OF SPOUSE _____	
CAUSE OF DEATH _____		MANNER OF DEATH _____	
MEDICAL HISTORY _____		SOCIAL HISTORY _____	
PHYSICIAN'S SIGNATURE _____		CORONER'S SIGNATURE _____	
MEDICAL EXAMINER'S SIGNATURE _____		COUNTY CLERK'S SIGNATURE _____	

BUREAU V. S.

MAR 10 1939

RECEIVED

1

RECEIVED

1

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Montgomery</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Poolesville</i>				c. LENGTH OF STAY IN 1b <i>2 years</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>L</i>				d. STREET ADDRESS <i>1</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>John</i> First <i>William</i> Middle <i>Butler</i> Last				4. DATE OF DEATH <i>March</i> Month <i>27</i> Day <i>1958</i> Year			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept-4-1877</i>	
9. AGE (In years lost birthday) <i>80</i> yrs.		IF UNDER 1 YEAR <i>6</i> Months <i>23</i> Days <i>1</i> Hours <i>2</i> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farming</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>farm</i>		11. BIRTHPLACE (State or foreign country) <i>London County, Eng</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Henry Whitney Butler</i>				14. MOTHER'S MAIDEN NAME <i>Fanny Lankhorne</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>214-32-8809</i>		17. INFORMANT <i>Gertrude H. Butler, Poolesville, Md</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broncho-pneumonia</i> <i>480X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Influenza</i> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i> <i>4 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>generalized arthritis</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>March-23-</i> , 1958, to <i>March-27-</i> , 1958, that I last saw the deceased alive on <i>March-27-</i> , 1958, and that death occurred at <i>9:10 P.M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>William C. Miller</i> M.D.				ADDRESS (Street, city or town, state) <i>7 - Brooks Avenue Gaithersburg, Md</i>			
DATE SIGNED							
PHYSICIAN'S NAME (Type) <i>WILLIAM C. MILLER</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/29/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Monksdale</i>		22d. LOCATION (City, town, or county) (State) <i>Beallsville Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William B. Hilton, Beallsville, Md</i>				ADDRESS		24a. REC'D BY REGISTRAR <i>DATE MAR 31 '58</i>	
				24b. REGISTRAR'S SIGNATURE <i>W. B. Hilton</i>			

CERTIFICATE OF DEATH

Page One

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>March 28, 1958</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. OCCUPATION <i>Teacher</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. MEDICAL HISTORY <i>None</i>		15. SURVIVAL <i>Yes</i>	
16. SIGNATURE OF DECEASED <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF PHYSICIAN <i>John Doe</i>	
19. SIGNATURE OF CORONER <i>John Doe</i>		20. SIGNATURE OF JURY <i>John Doe</i>		21. SIGNATURE OF JUDGE <i>John Doe</i>	

BUREAU V. S.

MAR 31 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3611

CERTIFICATE OF DEATH

03588

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Freeman Place</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>Shafor</u> Last <u>Shafor</u>		4. DATE OF DEATH Month <u>March</u> Day <u>30</u> Year <u>19 58</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/21/86</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>10</u> Hours <u>30</u> Min. <u>10</u>	IF UNDER 24 HRS. Months <u>7</u> Days <u>10</u> Hours <u>30</u> Min. <u>10</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph W. Shafor</u>		14. MOTHER'S MAIDEN NAME <u>Lizzie Anderson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Miss Lucille Shafor- as above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>420.1</u> DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 days</u> DUE TO (c) <u>2 days</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple Pulmonary emboli with pulmonary infarction</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1954</u> to <u>3/30/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/29/58</u> , 19 <u>58</u> , and that death occurred at <u>6:58 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1 Kensington, Md.</u> DATE SIGNED <u>3/30/58</u> ACTUAL SIGNATURE <u>Sam Allen MD</u> M.D. <u>Sam Allen MD</u> PHYSICIAN'S NAME (Type) <u>SAM Allen MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-trans</u>		22b. DATE THEREOF <u>4/1/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodside Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Middletown, Ohio</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey,</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>APR 3 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Allen Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 3 1952

RECEIVED

3612

CERTIFICATE OF DEATH

03589

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>15 Magnolia Parkway</u>				d. STREET ADDRESS <u>15 Magnolia Parkway</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>B.</u> Last <u>Shaw</u>				4. DATE OF DEATH Month <u>3</u> Day <u>22</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MAILED NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-11-1872</u>		9. AGE (In years last birthday) yrs. <u>86</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>S. R. Buxton</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Peele</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Henry M. Shaw</u>		Address <u>As above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Congestive heart failure</u> DUE TO (b) <u>Atherosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> <u>10 yrs +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Sept 1, 1942</u> to <u>Mar. 22, 1958</u> , that I last saw the deceased alive on <u>Mar. 22, 1958</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. Massie Page</u>				ADDRESS (Street, city or town, state) <u>1150 Conn. Ave. N.W. Wash. D.C.</u>			
PHYSICIAN'S NAME (Type) <u>R. Massie Page</u>				DATE SIGNED <u>3-22-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>3-23-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Henderson</u>		22d. LOCATION (City, town, or county) (State) <u>N. Carolina</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jos. Gawler's Sons</u>				ADDRESS <u>1756 Pa. Ave. N.W.</u>		24a. REC'D BY REGISTRAR <u>MAR 26 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>			

RECEIVED
MAR 26 1958
BUREAU V. S.

3613

CERTIFICATE OF DEATH

03591

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md.</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Garrett Park</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Alta Vista Rest Home</i>				d. STREET ADDRESS <i>11026 Kenilworth Ave</i>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>George Henry Smith</i>				4. DATE OF DEATH Month Day Year <i>March 25 1958</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 23 1888</i>	9. AGE (In years last birthday) <i>69</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Govt</i>		11. BIRTHPLACE (State or foreign country) <i>New Jersey</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>George Henry Smith Sr.</i>				14. MOTHER'S MAIDEN NAME <i>Williamenia Schilling</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT Address <i>Mrs. E. Harold Patterson 4710 Oxford St. Garrett Park, Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>332x Central thrombosis</i> DUE TO (b) <i>Cerebral arteriosclerosis</i> DUE TO (c) <i>1+yr</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1+yr</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <i>19</i>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>15 Mar 1958</i> to <i>25 Mar 1958</i> , that I last saw the deceased alive on <i>24 Mar 1958</i> , and that death occurred at <i>6:30 A.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>A. H. Richwine</i> M.D.				ADDRESS (Street, city or town, state) <i>5522 Western Ave Chevy Chase, Md</i> DATE SIGNED <i>25 Mar 1958</i>			
PHYSICIAN'S NAME (Type) <i>A. H. Richwine</i>				5522 Western Avenue, Chevy Chase, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/28/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Rock Creed Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Washington, D. C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i> ADDRESS <i>Bethesda, Maryland</i>				24a. REC'D BY REGISTRAR <i>28 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. J. ...</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

By Day 10

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 12/5/21		5. PLACE OF BIRTH MOBILE, ALA.	
6. OCCUPATION Singer		7. MARITAL STATUS Single		8. COLOR White		9. HIGHEST SCHOOLING High School		10. RELIGION Methodist	
11. CAUSE OF DEATH Suicide by gunshot		12. PLACE OF DEATH Rooming house, 1000 N. E. St., Baltimore, Md.		13. DATE OF DEATH 4/4/68		14. TIME OF DEATH 11:55 PM		15. SIGNATURE OF PHYSICIAN [Signature]	
16. SIGNATURE OF DECEASED [Signature]		17. SIGNATURE OF WITNESS [Signature]		18. SIGNATURE OF DECEASED [Signature]		19. SIGNATURE OF WITNESS [Signature]		20. SIGNATURE OF DECEASED [Signature]	
21. SIGNATURE OF DECEASED [Signature]		22. SIGNATURE OF WITNESS [Signature]		23. SIGNATURE OF DECEASED [Signature]		24. SIGNATURE OF WITNESS [Signature]		25. SIGNATURE OF DECEASED [Signature]	
26. SIGNATURE OF DECEASED [Signature]		27. SIGNATURE OF WITNESS [Signature]		28. SIGNATURE OF DECEASED [Signature]		29. SIGNATURE OF WITNESS [Signature]		30. SIGNATURE OF DECEASED [Signature]	
31. SIGNATURE OF DECEASED [Signature]		32. SIGNATURE OF WITNESS [Signature]		33. SIGNATURE OF DECEASED [Signature]		34. SIGNATURE OF WITNESS [Signature]		35. SIGNATURE OF DECEASED [Signature]	
36. SIGNATURE OF DECEASED [Signature]		37. SIGNATURE OF WITNESS [Signature]		38. SIGNATURE OF DECEASED [Signature]		39. SIGNATURE OF WITNESS [Signature]		40. SIGNATURE OF DECEASED [Signature]	
41. SIGNATURE OF DECEASED [Signature]		42. SIGNATURE OF WITNESS [Signature]		43. SIGNATURE OF DECEASED [Signature]		44. SIGNATURE OF WITNESS [Signature]		45. SIGNATURE OF DECEASED [Signature]	
46. SIGNATURE OF DECEASED [Signature]		47. SIGNATURE OF WITNESS [Signature]		48. SIGNATURE OF DECEASED [Signature]		49. SIGNATURE OF WITNESS [Signature]		50. SIGNATURE OF DECEASED [Signature]	
51. SIGNATURE OF DECEASED [Signature]		52. SIGNATURE OF WITNESS [Signature]		53. SIGNATURE OF DECEASED [Signature]		54. SIGNATURE OF WITNESS [Signature]		55. SIGNATURE OF DECEASED [Signature]	
56. SIGNATURE OF DECEASED [Signature]		57. SIGNATURE OF WITNESS [Signature]		58. SIGNATURE OF DECEASED [Signature]		59. SIGNATURE OF WITNESS [Signature]		60. SIGNATURE OF DECEASED [Signature]	
61. SIGNATURE OF DECEASED [Signature]		62. SIGNATURE OF WITNESS [Signature]		63. SIGNATURE OF DECEASED [Signature]		64. SIGNATURE OF WITNESS [Signature]		65. SIGNATURE OF DECEASED [Signature]	
66. SIGNATURE OF DECEASED [Signature]		67. SIGNATURE OF WITNESS [Signature]		68. SIGNATURE OF DECEASED [Signature]		69. SIGNATURE OF WITNESS [Signature]		70. SIGNATURE OF DECEASED [Signature]	
71. SIGNATURE OF DECEASED [Signature]		72. SIGNATURE OF WITNESS [Signature]		73. SIGNATURE OF DECEASED [Signature]		74. SIGNATURE OF WITNESS [Signature]		75. SIGNATURE OF DECEASED [Signature]	
76. SIGNATURE OF DECEASED [Signature]		77. SIGNATURE OF WITNESS [Signature]		78. SIGNATURE OF DECEASED [Signature]		79. SIGNATURE OF WITNESS [Signature]		80. SIGNATURE OF DECEASED [Signature]	
81. SIGNATURE OF DECEASED [Signature]		82. SIGNATURE OF WITNESS [Signature]		83. SIGNATURE OF DECEASED [Signature]		84. SIGNATURE OF WITNESS [Signature]		85. SIGNATURE OF DECEASED [Signature]	
86. SIGNATURE OF DECEASED [Signature]		87. SIGNATURE OF WITNESS [Signature]		88. SIGNATURE OF DECEASED [Signature]		89. SIGNATURE OF WITNESS [Signature]		90. SIGNATURE OF DECEASED [Signature]	
91. SIGNATURE OF DECEASED [Signature]		92. SIGNATURE OF WITNESS [Signature]		93. SIGNATURE OF DECEASED [Signature]		94. SIGNATURE OF WITNESS [Signature]		95. SIGNATURE OF DECEASED [Signature]	
96. SIGNATURE OF DECEASED [Signature]		97. SIGNATURE OF WITNESS [Signature]		98. SIGNATURE OF DECEASED [Signature]		99. SIGNATURE OF WITNESS [Signature]		100. SIGNATURE OF DECEASED [Signature]	

BUREAU V. S.

MAR 123 1958

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3614 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03592

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>800 Dale Dr</u>		1. STREET ADDRESS <u>800 Dale Dr</u>	
3. NAME OF DECEASED (Type or print) <u>Oscar Nathaniel Smith</u>		4. DATE OF DEATH <u>Mar 24 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 25 1885</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Dep. of Justice</u>	
13. FATHER'S NAME <u>Wilson Smith</u>		14. MOTHER'S MAIDEN NAME <u>Violet Pickett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Wm Smith</u>		18. ADDRESS <u>1901 N N.W. Wash DC</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> <u>433.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Heart Block</u> (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Mar. 24 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>3/26/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CEPARD HILL</u>		22d. LOCATION (City, town, or county) (State) <u>SOUTLAND, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph F. Birch'sons</u>		ADDRESS <u>WASHINGTON D.C.</u>	
24a. REC'D BY REGISTRAR <u>MAR 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

RECEIVED

MAR 26 1958

BUREAU V. E.

STATE
HEALTH DEPT

INSTRUCTIONS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03593

3475

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Pk Md.</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San & Hosp</u>				d. STREET ADDRESS <u>105 Waterford Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Scott</u> Middle <u>Royal</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>Mar</u> Day <u>31</u> Year <u>1958</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/20/53</u>		9. AGE (In years last birthday) <u>4</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHILD</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Royal L. Smith</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET E. Brannum</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Hoy. Record</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>475X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>Edema of Glottis</u> DUE TO (c) <u>upper Acute Respiratory Infection</u>							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>?</u> <u>24 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		3-31-58	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/3/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>APR 7 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. E. Humphrey</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3615 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03594

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Yorktown Village</u>		c. LENGTH OF STAY IN 1b <u>9 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. 16</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sidney Victor Smith</u>		4. DATE OF DEATH <u>Mar 3 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-21-1903</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR: Months <u>3</u> Days <u>3</u> Hours <u>12</u> Min. <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N.Y.</u>	
11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Christopher Smith</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Hearn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-52-4938</u>	
17. INFORMANT <u>Mrs. Frances Smith, Yorktown Village, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous attack</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>3-3-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>3/5/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gawler's Sons, Inc.</u> ADDRESS <u>1756 Pa. Ave., N.W., DC</u>		24a. REC'D BY REGISTRAR <u>Al. Leach</u> DATE <u>MAR 6 '58</u>	
24b. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAR 6 1938

RECEIVED

3616
CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		d. STREET ADDRESS 1133 Peyton-Randolph Drive	
3. NAME OF DECEASED (Type or print) First Anthony Middle Leonard Last SMOLSKY		4. DATE OF DEATH Month March Day 13 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 25 Feb. 1958
9. AGE (In years last birthday) yrs. 16		IF UNDER 1 YEAR Months 16 Days 13 Hours 13 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Matt (n) SMOLSKY		14. MOTHER'S MAIDEN NAME Anise Louise JUSTICE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Father) Matt SMOLSKY (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.5 Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital Heart Disease (Truncus) DUE TO (c) 2 hrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 763.0 Severe pneumonia which caused cardiac decompensation 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10 March , 19 58 , to 13 March , 19 58 , that I last saw the deceased alive on 13 March , 19 58 , and that death occurred at 1:30 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Adam G. Thorp, Jr. M.D. U.S. Naval Hospital, Bethesda, Md.		3-14-58	
PHYSICIAN'S NAME (Type) Adam G. Thorp, Jr. LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-17-58	
22c. NAME OF CEMETERY OR CREMATORY Private Cemetery		22d. LOCATION (City, town, or county) (State) Beckley, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Inc.		ADDRESS W.W. Chambers, 1400 Chapin St. N.W. Washington, D.C.	
24a. REC'D BY REGISTRAR MAR 17 58		24b. REGISTRAR'S SIGNATURE Adelbert	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Name (Print)		Sex		Age	
Date of Birth		Place of Birth		Usual Residence	
Cause of Death		Manner of Death		Occupation	
Date of Death		Time of Death		Place of Death	
Signature of Physician		Signature of Registrar		Signature of Informant	

BUREAU V. E.

MAR 17 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3476

Item 7 Film 6226 3-21-58 et

CERTIFICATE OF DEATH

03596

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>17 Takoma Park.</i>	
c. LENGTH OF STAY IN 1b <i>17 days</i>		d. STREET ADDRESS <i>904 Davis Ave</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Nat'l San. Hosp</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Nertie May Stimson</i>		4. DATE OF DEATH Month <i>3</i> Day <i>16</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-15-85</i>
9. AGE (In years last birthday) <i>73</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Wisconsin</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Lorenzo Austin</i>		14. MOTHER'S MAIDEN NAME <i>Alzina Warren</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>None</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Daughter (Mrs Evelyn Pearson)</i>		Address <i>904 Davis Ave. T. Park</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adeno carcinoma of bladder with metastasis</i> DUE TO (b) <i>Acute cardiac failure</i> DUE TO (c) <i>Acute cardiac failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2/23/1958</i> to <i>3/16/1958</i> , that I last saw the deceased alive on <i>3/16/1958</i> , and that death occurred at <i>1045</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Howard T. Morse M.D.</i>		DATE SIGNED <i>Mar 18 '58</i>	
PHYSICIAN'S NAME (Type) <i>HOWARD T. MORSE</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Mar 26 '58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>FOREST HILL CEM</i>		22d. LOCATION (City, town, or county) (State) <i>MADISON Wisc</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur J. Hall</i>		24a. REC'D BY REGISTRAR <i>W. J. Leach</i>	
ADDRESS <i>254 Carroll St NW</i>		DATE <i>MAR 18 '58</i>	

CERTIFICATE OF DEATH

The Day of

PLACE OF DEATH

HABITATION

DATE OF DEATH

NAME OF DECEASED

SEX

AGE

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

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PLACE OF DEATH

CAUSE OF DEATH

BUREAU V. S.

MAR 18 1958

RECEIVED

Handwritten signature and notes at the bottom of the page.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03597

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

3617

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 11 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 12,817 GEORGIA AVENUE		d. STREET ADDRESS 12,817 GEORGIA AVENUE	
3. NAME OF DECEASED (Type or print) CLARENCE LYNN STURDEVANT		4. DATE OF DEATH Month MARCH Day 31 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/1/85
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Prof. soldier (retired)		12. KIND OF BUSINESS OR INDUSTRY U. S. Army	
13. BIRTHPLACE (State or foreign country) Neillsville, Wisconsin		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME Lafayette M. Sturdevant		16. MOTHER'S MAIDEN NAME Minette Bacon	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		18. SOCIAL SECURITY NO. WW #1 & WW #2 577-50-82364	
19. INFORMANT Address Mrs. Beth Y. Sturdevant, 12,817 Ga. Ave. Silver Spring, Maryland		20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) sudden DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		23. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
24. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		25. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
26. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		27. (City or town) (County) (State)	
28. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. BROSCART		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 3/31/58	
29a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		29b. DATE THEREOF 4/3/58	
30a. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L CEMETERY		30b. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
31. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		ADDRESS SILVER SPRING, MD.	
32. REC'D BY REGISTRAR APR 3 '58		33. REGISTRAR'S SIGNATURE W. E. Humphrey	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Figure 6

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BUREAU V. S.

APR 3 1953

RECEIVED

CERTIFICATE OF DEATH

03598

Reg. Dist. No. 215

3618

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE VIRGINIA b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA (RURAL)				c. LENGTH OF STAY IN 1b 1MO. 11DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. NAVAL HOSPITAL BETHESDA, MD.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RUBY Middle MARIE Last TEDESCO				4. DATE OF DEATH Month MARCH Day 29 Year 19 58			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11 NOVEMBER 1924	
9. AGE (In years last birthday) 33 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME HARRY A. GRAY				14. MOTHER'S MAIDEN NAME ELSIE SOUTHERN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT (HUSBAND) GEORGE E. TEDESCO (SAME AS # 2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA METASTATIC BREAST 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 4 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 17 FEBRUARY, 19 58 , to 29 MARCH, 19 58 , that I last saw the deceased alive on 29 MARCH, 19 58 , and that death occurred at 5:30 P. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE R.G. Galbraith				ADDRESS (Street, city or town, state) U.S. NAVAL HOSPITAL BETHESDA, MD.			
DATE SIGNED							
PHYSICIAN'S NAME (Type) R.G. GALBRAITH LT MC U S N				U.S. NAVAL HOSPITAL BETHESDA, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-1-58		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L CEMETARY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE BRADLEY'S FUNERAL HOME				ADDRESS LURAY, VIRGINIA		24a. REC'D BY REGISTRAR DATE APR 3 1958	
24b. REGISTRAR'S SIGNATURE Alfred Smith							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

JACKSON STATE DEPARTMENT OF HEALTH - BALTIMORE 10

DATE OF DEATH

APR 3 1938

APR 3 1938

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APR 3 1938

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WISCONSIN

3619

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 157 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Michigan b. COUNTY Wayne		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Inkster		d. STREET ADDRESS 4379 Bridgeport Court		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rosa Middle Belle Last Teel		4. DATE OF DEATH Month March Day 1, Year 19 58		5. SEX Female		6. COLOR OR RACE Negroid		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 6, 1921		9. AGE (In years last birthday) 36 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME John Marks		14. MOTHER'S MAIDEN NAME Mary (Unknown)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. Not available		17. INFORMANT The Medical Record		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Chorio Carcinoma - uterus DUE TO to brain - with increased intracranial pressure & papilledema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. also, metastases to lungs, liver, spleen, & right kidney. (b) (c) INTERVAL BETWEEN ONSET AND DEATH 12-13 months		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) See above.		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Bethesda		(County) Montgomery		(State) Md.			
21. I certify that I attended the deceased from September 25, 19 57 , to March 1, 19 58 , that I last saw the deceased alive on March 1, 19 58 , and that death occurred at 12:50 P. from the causes and on the date stated above.													
ACTUAL SIGNATURE S. Kahn M.D.		M.D. The Clinical Center		ADDRESS (Street, city or town, state) The National Institutes of Health		DATE SIGNED March 1, 1958		PHYSICIAN'S NAME (Type) S. Kahn, M. D.		ADDRESS Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Max. 2		22b. DATE THEREOF Mar. 2		22c. NAME OF CEMETERY OR CREMATORY Detroit Mich.		22d. LOCATION (City, town, or county) Mich.		(State) Mich.		23. FUNERAL DIRECTOR'S SIGNATURE FRAZIER'S FUNERAL HOME			
24a. REC'D BY REGISTRAR MAR 6 '58		24b. REGISTRAR'S SIGNATURE Reese		24c. REGISTRAR'S SIGNATURE Reese		24d. REGISTRAR'S SIGNATURE Reese		24e. REGISTRAR'S SIGNATURE Reese		24f. REGISTRAR'S SIGNATURE Reese			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3573

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. 3

MAR 6 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar's name, to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3620

CERTIFICATE OF DEATH

03600

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Resmor Sanitarium				d. STREET ADDRESS 6509 River Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Bertram Middle manley Last Teskey				4. DATE OF DEATH Month March Day 6 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 19, 1880		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months 4 Days 17 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Exec-AT & T Co		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Teskey				14. MOTHER'S MAIDEN NAME Helen Horne			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Charles Teskey		Address Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of liver DUE TO (c) pneumonia of left chest							INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 8 months 2 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized atherosclerosis enlarged heart & aorta							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. ft. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from 2/15 , 19 58 , to 3/6 , 19 58 , that I last saw the deceased alive on 3/6/58 , and that death occurred at 11:45 A.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)						DATE SIGNED	
ACTUAL SIGNATURE S. A. Thomas				M.D. 4301 45th St NW		3/6/58	
PHYSICIAN'S NAME (Type) S. A. Thomas MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit		22b. DATE THEREOF 3-8-58		22c. NAME OF CEMETERY OR CREMATORY St. James Cemetery		22d. LOCATION (City, town, or county) (State) Orillia, Ontario, Canada.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE MAR 12 '58		24b. REGISTRAR'S SIGNATURE W. Search	

CERTIFICATE OF DEATH

See Div. 100

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. DATE OF BIRTH 1873		5. PLACE OF BIRTH Maryland	
6. OCCUPATION Farmer		7. CAUSE OF DEATH Heart Disease		8. PLACE OF DEATH Home		9. DATE OF DEATH 1938		10. TIME OF DEATH 10:00 AM	
11. SIGNATURE OF PHYSICIAN J. H. Harris		12. SIGNATURE OF WITNESSES J. H. Harris		13. SIGNATURE OF DECEASED J. H. Harris		14. SIGNATURE OF CLERK J. H. Harris		15. SIGNATURE OF REGISTRAR J. H. Harris	
16. NAME OF CLERK J. H. Harris		17. NAME OF REGISTRAR J. H. Harris		18. NAME OF PHYSICIAN J. H. Harris		19. NAME OF WITNESSES J. H. Harris		20. NAME OF DECEASED J. H. Harris	
21. NAME OF CLERK J. H. Harris		22. NAME OF REGISTRAR J. H. Harris		23. NAME OF PHYSICIAN J. H. Harris		24. NAME OF WITNESSES J. H. Harris		25. NAME OF DECEASED J. H. Harris	
26. NAME OF CLERK J. H. Harris		27. NAME OF REGISTRAR J. H. Harris		28. NAME OF PHYSICIAN J. H. Harris		29. NAME OF WITNESSES J. H. Harris		30. NAME OF DECEASED J. H. Harris	
31. NAME OF CLERK J. H. Harris		32. NAME OF REGISTRAR J. H. Harris		33. NAME OF PHYSICIAN J. H. Harris		34. NAME OF WITNESSES J. H. Harris		35. NAME OF DECEASED J. H. Harris	
36. NAME OF CLERK J. H. Harris		37. NAME OF REGISTRAR J. H. Harris		38. NAME OF PHYSICIAN J. H. Harris		39. NAME OF WITNESSES J. H. Harris		40. NAME OF DECEASED J. H. Harris	
41. NAME OF CLERK J. H. Harris		42. NAME OF REGISTRAR J. H. Harris		43. NAME OF PHYSICIAN J. H. Harris		44. NAME OF WITNESSES J. H. Harris		45. NAME OF DECEASED J. H. Harris	
46. NAME OF CLERK J. H. Harris		47. NAME OF REGISTRAR J. H. Harris		48. NAME OF PHYSICIAN J. H. Harris		49. NAME OF WITNESSES J. H. Harris		50. NAME OF DECEASED J. H. Harris	
51. NAME OF CLERK J. H. Harris		52. NAME OF REGISTRAR J. H. Harris		53. NAME OF PHYSICIAN J. H. Harris		54. NAME OF WITNESSES J. H. Harris		55. NAME OF DECEASED J. H. Harris	
56. NAME OF CLERK J. H. Harris		57. NAME OF REGISTRAR J. H. Harris		58. NAME OF PHYSICIAN J. H. Harris		59. NAME OF WITNESSES J. H. Harris		60. NAME OF DECEASED J. H. Harris	
61. NAME OF CLERK J. H. Harris		62. NAME OF REGISTRAR J. H. Harris		63. NAME OF PHYSICIAN J. H. Harris		64. NAME OF WITNESSES J. H. Harris		65. NAME OF DECEASED J. H. Harris	
66. NAME OF CLERK J. H. Harris		67. NAME OF REGISTRAR J. H. Harris		68. NAME OF PHYSICIAN J. H. Harris		69. NAME OF WITNESSES J. H. Harris		70. NAME OF DECEASED J. H. Harris	
71. NAME OF CLERK J. H. Harris		72. NAME OF REGISTRAR J. H. Harris		73. NAME OF PHYSICIAN J. H. Harris		74. NAME OF WITNESSES J. H. Harris		75. NAME OF DECEASED J. H. Harris	
76. NAME OF CLERK J. H. Harris		77. NAME OF REGISTRAR J. H. Harris		78. NAME OF PHYSICIAN J. H. Harris		79. NAME OF WITNESSES J. H. Harris		80. NAME OF DECEASED J. H. Harris	
81. NAME OF CLERK J. H. Harris		82. NAME OF REGISTRAR J. H. Harris		83. NAME OF PHYSICIAN J. H. Harris		84. NAME OF WITNESSES J. H. Harris		85. NAME OF DECEASED J. H. Harris	
86. NAME OF CLERK J. H. Harris		87. NAME OF REGISTRAR J. H. Harris		88. NAME OF PHYSICIAN J. H. Harris		89. NAME OF WITNESSES J. H. Harris		90. NAME OF DECEASED J. H. Harris	
91. NAME OF CLERK J. H. Harris		92. NAME OF REGISTRAR J. H. Harris		93. NAME OF PHYSICIAN J. H. Harris		94. NAME OF WITNESSES J. H. Harris		95. NAME OF DECEASED J. H. Harris	
96. NAME OF CLERK J. H. Harris		97. NAME OF REGISTRAR J. H. Harris		98. NAME OF PHYSICIAN J. H. Harris		99. NAME OF WITNESSES J. H. Harris		100. NAME OF DECEASED J. H. Harris	

RECEIVED
MAR 12 1938
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3621

CERTIFICATE OF DEATH

03601

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 101 E. Lenox Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Susan Middle W. Last TEWKSBURY		4. DATE OF DEATH Month March Day 28 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1885
9. AGE (In years last birthday) yrs. 72		IF UNDER 1 YEAR Months 10 Days 9	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Alexander West		14. MOTHER'S MAIDEN NAME Lucy Hinton Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. John H. King-4116 Blackthorn St. Ch. Ch. Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrhythmia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) 2 years		INTERVAL BETWEEN ONSET AND DEATH. 1 min 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 6, 1956 , to March 28, 1958 , that I last saw the deceased alive on January 24, 1958 , and that death occurred at 6:00 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE Michel M Healy M.D.		ADDRESS (Street, city or town, state) DATE SIGNED Washington, D.C. Wash. DC March 28 1958	
PHYSICIAN'S NAME (Type) Michel M. Healy, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/1/1958	
22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md		24a. REC'D BY REGISTRAR MAR 31 '58	
		24b. REGISTRAR'S SIGNATURE Deed Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		MAY 12, 1958	
AGE		SEX	
68		M	
RACE		EDUCATION	
W		H	
BIRTHPLACE		RESIDENCE	
MD		MD	
OCCUPATION		CAUSE OF DEATH	
R		H	
MANNER OF DEATH		PLACE OF DEATH	
N		H	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. H. HARRIS		J. H. HARRIS	

BUREAU V. 3

MAR 31 1958

RECEIVED

3622

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Wash. D.C.</u> b. COUNTY <u>Wash. D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washingt., D.C.</u> <u>47x-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>4212 Military Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Anderson</u> Middle <u>H.</u> Last <u>Thompson</u>				4. DATE OF DEATH Month <u>1055</u> Day <u>2</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 8. 1885</u>		9. AGE (In years lost birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mg. Swift Pack Co.</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John Lee Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Wif e</u>		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Anterior sclerotic condiparal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>5 days</u> (c) <u>5 days</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Feb 26</u> , 19 <u>58</u> , to <u>March 2</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>March 1</u> , 19 <u>58</u> , and that death occurred at <u>10:35 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald O. Elman</u>		M.D. <u>5707 Wisconsin ave</u>		ADDRESS (Street, city or town, state)		DATE SIGNED <u>3/2/58</u>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/5/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>East Lincoln cem</u>		22d. LOCATION (City, town, or county) (State) <u>Shadensburg Rd Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home</u>		ADDRESS <u>5703 Wisconsin</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 6 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1958

BUREAU V. B.

MAR 6 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3623

CERTIFICATE OF DEATH

03603

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>10 hrs. 20"</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>(None)</u> Last <u>Tobias</u>				4. DATE OF DEATH Month <u>3</u> Day <u>23</u> Year <u>1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 22 '14</u>	
9. AGE (In years lost birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>3</u>		IF UNDER 24 HRS. Hours <u>4</u> Min. <u>3</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales manager</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Wholesale food</u>			
11. BIRTHPLACE (State or foreign country) <u>New Haven Conn.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Abraham Joseph Tobias (Dec.)</u>				14. MOTHER'S MAIDEN NAME <u>Kravitz Dora</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWY-W.W. II</u>				16. SOCIAL SECURITY NO. <u>091-03-035</u>			
17. INFORMANT <u>Celia Tobias</u>				Address <u>2519 PLYERS MILL RD. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute heart failure</u> 420.1 DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary thrombosis</u> (c) <u>1 day</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 day</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>March 20 1958</u> , to <u>March 23 1958</u> , that I last saw the deceased alive on <u>March 23, 1958</u> , and that death occurred at <u>9:25 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John J. Curry</u> M.D. <u>10620 Georgia Ave</u>				DATE SIGNED <u>3/23/58</u>			
PHYSICIAN'S NAME (Type) <u>Silver Spring, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/25/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>KESHER ISRAEL CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>CAPITOL HTS., MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u> ADDRESS <u>4217-9th St NW</u>				24a. REC'D BY REGISTRAR <u>MAR 26 1958</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>	

CERTIFICATE OF DEATH

BUREAU V. S.

MAR 26 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03604

3624

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boyd,			c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Boyd,		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LUMMIE V. TURNER				4. DATE OF DEATH Month Day Year March 15, 19 58			
5. SEX female		6. COLOR OR RACE colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 14, 1900	
9. AGE (In years last birthday) yrs. 58		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ----		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Edward Campbell				14. MOTHER'S MAIDEN NAME Sarah Bowen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Oscar Turner.,		Address Boyd, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Rectum DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 year 7 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7 March, 1958 , to 15 March, 1958 , that I last saw the deceased alive on 15 March, 1958 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Gordon M. Smith		M.D. Boyd, Maryland		DATE SIGNED 15 March 58			
PHYSICIAN'S NAME (Type) Gordon M. Smith							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/19/58		22c. NAME OF CEMETERY OR CREMATORY St. Marks.,		22d. LOCATION (City, town, or county) (State) Boyd, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE MAR 21 1958	
				24b. REGISTRAR'S SIGNATURE W. J. Seach			

CERTIFICATE OF DEATH

DECEASED		DATE OF DEATH	
PLACE OF DEATH		AGE	
SEX		RACE	
MARRIED		OCCUPATION	
EDUCATION		RELIGION	
BIRTH		DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
DISEASE		SYMPTOMS	
TREATMENT		HISTORY	
FAMILY HISTORY		SOCIAL HISTORY	
MEDICAL HISTORY		LABORATORY TESTS	
PATHOLOGICAL FINDINGS		MICROSCOPIC FINDINGS	
GROSS FINDINGS		HISTOLOGICAL FINDINGS	
IMPRESSION		REMARKS	
SIGNATURE		DATE	

RECEIVED
MAR 21 1958
BUREAU V. 1

CERTIFICATE OF DEATH

Reg. Dist. No. 03605

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> by COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RD1 Gaithersburg</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>xRD1 Gaithersburg</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>RD1 Gaithersburg</i>	
3. NAME OF DECEASED (Type or print) <i>William Henry Tyler</i>		4. DATE OF DEATH Month <i>3</i> Day <i>2</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-7-1875</i>
9. AGE (In years last birthday) <i>82</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>PREACHER</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Robert Henry Tyler</i>		14. MOTHER'S MAIDEN NAME <i>JANE MOORE</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT Address <i>RUIZE Tyler, Son, RD1 Gaithersburg</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatosis</i> <i>199.1</i> DUE TO <i>Epidermoid carcinoma, primary, Lt. Thigh</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Epidermoid carcinoma, primary, Lt. Thigh</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Emaciation</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>8-2-</i> 19 <i>50</i> to <i>3-2-</i> 19 <i>58</i> , that I last saw the deceased alive on <i>3-1-</i> 19 <i>58</i> , and that death occurred at <i>3:30 A.</i> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>RD1 Gaithersburg, Md.</i> DATE SIGNED <i>3-2-58</i>			
ACTUAL SIGNATURE <i>Clive E. Jackson</i>		PHYSICIAN'S NAME (Type) <i>RD1 Gaithersburg, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3/5/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Emory Grove,.</i>	22d. LOCATION (City, town, or county) (State) <i>Emory Grove, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Snowden</i> ADDRESS <i>Rockville, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>MAR 7 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Quelch</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 7 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03606

3626

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown - Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown - Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>BEALL W. UNGLESBEE</u>		4. DATE OF DEATH <u>March 9, 1958</u> 19	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/8/70</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR <u>9</u> Months <u>1</u> Days IF UNDER 24 HRS. <u>1</u> Hours <u></u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Owner</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George W. Unglesbee</u>		14. MOTHER'S MAIDEN NAME <u>Annie C. Hiens</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mary E. Unglesbee-Item# 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Sclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-8</u> , 19 <u>58</u> , to <u>3-9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3-9</u> , 19 <u>58</u> , and that death occurred at <u>8:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Vernon E. Martens</u> M.D.		ADDRESS (Street, city or town, state) <u>Germantown</u> DATE SIGNED <u>3-10-58</u>	
PHYSICIAN'S NAME (Type) <u>Vernon E. Martens</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/14/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Neelsville Church Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Neelsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumpfrey-Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 13 '58</u> 24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 13 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3627

CERTIFICATE OF DEATH

03607

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>107 Lexington Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>Susan</u> First <u>E.</u> Middle <u>Unklesbee</u> Last		4. DATE OF DEATH <u>March 10 1958</u> Month <u>March</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 23, 1879</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>78</u> Days <u>78</u> Hours <u>78</u> Min. <u>78</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Bowser</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Thompson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cerebrovascular accident</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs</u> <u>Several years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 1957</u> to <u>March 10 1958</u> , that I last saw the deceased alive on <u>March 10 1958</u> and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bennet A. Porter, Jr., M.D.</u>		ADDRESS (Street, city or town, state) <u>9301 Colesville Rd, Silver Spring, Md.</u> DATE SIGNED <u>March 11, 1958</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>3-13-58</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Silver Spring Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Funeral Home with</u>		24. REC'D BY REGISTRAR <u>W. B. Beach</u>	
ADDRESS		DATE <u>MAR 13 1958</u>	
24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

MAR 13 1958

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3628

CERTIFICATE OF DEATH

03608

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brooke Grove Foundation		d. STREET ADDRESS 13,118 Bluhill Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Dorothy Last Upperman		4. DATE OF DEATH Month 3 Day 23 Year 19 58	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/26/71
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Fox		14. MOTHER'S MAIDEN NAME Mary Betz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. Noble A. Upperman, 13118 Bluhill Road Silver Spring, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General Arterio Sclerosis DUE TO 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Hemorrhage DUE TO Hypertension (c) 2 INTERVAL BETWEEN ONSET AND DEATH 6 mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 58		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/18/58 to 3/23/58 , that I last saw the deceased alive on 3/18/58 , and that death occurred at 5:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sandy Sp... DATE SIGNED J. W. Bird			
ACTUAL SIGNATURE J. W. Bird		M.D. Sandy Sp...	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/25/58	
22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR MAR 26 '58	
24b. REGISTRAR'S SIGNATURE W. E. Humphrey			

MAR 26 1958

RECEIVED

3477

CERTIFICATE OF DEATH

03609

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Ontario, Canada</u> o. COUNTY <u>Canada</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ont., Canada 90x-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>Tamworth, Ont.</u>			
3. NAME OF DECEASED (Type or print) <u>First Middle Last</u> <u>Lily Frances VanDusen</u>				4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-12-82</u>	9. AGE (In years last birthday) <u>75 yrs.</u>	IF UNDER 1 YEAR Months <u>75</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hsuf.</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Canada</u>	
13. FATHER'S NAME <u>Henry R. Young</u>				14. MOTHER'S MAIDEN NAME <u>Emily Young</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Chart of St.</u>		17. INFORMANT <u>Chart of St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cerebrovascular disease</u> DUE TO (c) <u>15 yrs.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January</u> , 19 <u>58</u> , to <u>March 24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>March 24</u> , 19 <u>58</u> , and that death occurred at <u>6:00 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. W. Whitlock</u>				ADDRESS (Street, city or town, state) <u>2201 Carroll Ave Takoma Park 12 Maryland</u>			
DATE SIGNED <u>3-24-58</u>				M.D. <u>3-24-58</u>			
PHYSICIAN'S NAME (Type) <u>J. W. WHITLOCK</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 28, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Anglican Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Tamworth, Ontario, Canada</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hall</u>				ADDRESS <u>D.C. 254 Carroll St NW</u>		24d. REC'D BY REGISTRAR <u>MR 26 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. J. Hall</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. MEDICAL HISTORY	
10. DATE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF DECEASED	
13. SIGNATURE OF WITNESSES		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR	
16. SIGNATURE OF CLERK		17. SIGNATURE OF JURY		18. SIGNATURE OF JUDGE	
19. SIGNATURE OF SHERIFF		20. SIGNATURE OF SHERIFF'S CLERK		21. SIGNATURE OF SHERIFF'S DEPUTY	
22. SIGNATURE OF SHERIFF'S DEPUTY		23. SIGNATURE OF SHERIFF'S DEPUTY		24. SIGNATURE OF SHERIFF'S DEPUTY	
25. SIGNATURE OF SHERIFF'S DEPUTY		26. SIGNATURE OF SHERIFF'S DEPUTY		27. SIGNATURE OF SHERIFF'S DEPUTY	
28. SIGNATURE OF SHERIFF'S DEPUTY		29. SIGNATURE OF SHERIFF'S DEPUTY		30. SIGNATURE OF SHERIFF'S DEPUTY	
31. SIGNATURE OF SHERIFF'S DEPUTY		32. SIGNATURE OF SHERIFF'S DEPUTY		33. SIGNATURE OF SHERIFF'S DEPUTY	
34. SIGNATURE OF SHERIFF'S DEPUTY		35. SIGNATURE OF SHERIFF'S DEPUTY		36. SIGNATURE OF SHERIFF'S DEPUTY	
37. SIGNATURE OF SHERIFF'S DEPUTY		38. SIGNATURE OF SHERIFF'S DEPUTY		39. SIGNATURE OF SHERIFF'S DEPUTY	
40. SIGNATURE OF SHERIFF'S DEPUTY		41. SIGNATURE OF SHERIFF'S DEPUTY		42. SIGNATURE OF SHERIFF'S DEPUTY	
43. SIGNATURE OF SHERIFF'S DEPUTY		44. SIGNATURE OF SHERIFF'S DEPUTY		45. SIGNATURE OF SHERIFF'S DEPUTY	
46. SIGNATURE OF SHERIFF'S DEPUTY		47. SIGNATURE OF SHERIFF'S DEPUTY		48. SIGNATURE OF SHERIFF'S DEPUTY	
49. SIGNATURE OF SHERIFF'S DEPUTY		50. SIGNATURE OF SHERIFF'S DEPUTY		51. SIGNATURE OF SHERIFF'S DEPUTY	
52. SIGNATURE OF SHERIFF'S DEPUTY		53. SIGNATURE OF SHERIFF'S DEPUTY		54. SIGNATURE OF SHERIFF'S DEPUTY	
55. SIGNATURE OF SHERIFF'S DEPUTY		56. SIGNATURE OF SHERIFF'S DEPUTY		57. SIGNATURE OF SHERIFF'S DEPUTY	
58. SIGNATURE OF SHERIFF'S DEPUTY		59. SIGNATURE OF SHERIFF'S DEPUTY		60. SIGNATURE OF SHERIFF'S DEPUTY	
61. SIGNATURE OF SHERIFF'S DEPUTY		62. SIGNATURE OF SHERIFF'S DEPUTY		63. SIGNATURE OF SHERIFF'S DEPUTY	
64. SIGNATURE OF SHERIFF'S DEPUTY		65. SIGNATURE OF SHERIFF'S DEPUTY		66. SIGNATURE OF SHERIFF'S DEPUTY	
67. SIGNATURE OF SHERIFF'S DEPUTY		68. SIGNATURE OF SHERIFF'S DEPUTY		69. SIGNATURE OF SHERIFF'S DEPUTY	
70. SIGNATURE OF SHERIFF'S DEPUTY		71. SIGNATURE OF SHERIFF'S DEPUTY		72. SIGNATURE OF SHERIFF'S DEPUTY	
73. SIGNATURE OF SHERIFF'S DEPUTY		74. SIGNATURE OF SHERIFF'S DEPUTY		75. SIGNATURE OF SHERIFF'S DEPUTY	
76. SIGNATURE OF SHERIFF'S DEPUTY		77. SIGNATURE OF SHERIFF'S DEPUTY		78. SIGNATURE OF SHERIFF'S DEPUTY	
79. SIGNATURE OF SHERIFF'S DEPUTY		80. SIGNATURE OF SHERIFF'S DEPUTY		81. SIGNATURE OF SHERIFF'S DEPUTY	
82. SIGNATURE OF SHERIFF'S DEPUTY		83. SIGNATURE OF SHERIFF'S DEPUTY		84. SIGNATURE OF SHERIFF'S DEPUTY	
85. SIGNATURE OF SHERIFF'S DEPUTY		86. SIGNATURE OF SHERIFF'S DEPUTY		87. SIGNATURE OF SHERIFF'S DEPUTY	
88. SIGNATURE OF SHERIFF'S DEPUTY		89. SIGNATURE OF SHERIFF'S DEPUTY		90. SIGNATURE OF SHERIFF'S DEPUTY	
91. SIGNATURE OF SHERIFF'S DEPUTY		92. SIGNATURE OF SHERIFF'S DEPUTY		93. SIGNATURE OF SHERIFF'S DEPUTY	
94. SIGNATURE OF SHERIFF'S DEPUTY		95. SIGNATURE OF SHERIFF'S DEPUTY		96. SIGNATURE OF SHERIFF'S DEPUTY	
97. SIGNATURE OF SHERIFF'S DEPUTY		98. SIGNATURE OF SHERIFF'S DEPUTY		99. SIGNATURE OF SHERIFF'S DEPUTY	
100. SIGNATURE OF SHERIFF'S DEPUTY		101. SIGNATURE OF SHERIFF'S DEPUTY		102. SIGNATURE OF SHERIFF'S DEPUTY	

RECEIVED
MAR 26 1958
BUREAU V. S.

Handwritten signature and date: 24 March 1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3629

CERTIFICATE OF DEATH

Reg. Dist. 02310

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 2 hrs. 43 min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NMMC, Bethesda Md.				d. STREET ADDRESS 2 Knot Green S.W.			
3. NAME OF DECEASED (Type or print) First Michael Middle (n) Last VERBANIC				4. DATE OF DEATH Month March Day 7 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7 March 1958	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months 2 Days 43		IF UNDER 24 HRS. Hours 2 Min. 43			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Joseph Robert VERBANIC				14. MOTHER'S MAIDEN NAME Willa J. SANFORD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None				17. INFORMANT (Father) Joseph Robert VERBANIC (Same as #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fetal atelectasis (c) Immaturity (500 gms weight)				INTERVAL BETWEEN ONSET AND DEATH 2 hrs 43 min 2 hrs 43 min			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 7 March , 19 58 , to 7 March , 19 58 , that I last saw the deceased alive on 7 March , 19 58 , and that death occurred at 8:10 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE John H. Mazur				M.D. U.S. Naval Hospital, Bethesda Md. 3-8-58			
PHYSICIAN'S NAME (Type) J.H. MAZUR LT MC USN				U.S. Naval Hospital, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		3-12-58		Arlington National Cemetery		Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey 755 Wisconsin Ave., Bethesda Md.				24a. RECEIVED BY REGISTRAR 11 58		24b. REGISTRAR'S SIGNATURE W. J. ...	

CERTIFICATE OF DEATH

BUREAU V. S.

MAR 11 1958

RECEIVED

3630
CERTIFICATE OF DEATH

Reg. Dist. No. 215

03611
215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Mooreland Hgts.	
c. LENGTH OF STAY IN 1b 10 days		d. STREET ADDRESS 5325 Carvel Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle (nmn) Last WADSWORTH		4. DATE OF DEATH Month March Day 5 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 April 1893
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Career Diplomat, Foreign Service, U.S. Gov't		10b. KIND OF BUSINESS OR INDUSTRY New York	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Cowles WADSWORTH		14. MOTHER'S MAIDEN NAME Mabel MILLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Daughter) Mrs. Cardine W. Harris (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) post-operative complication DUE TO (c) of Resection Carcinoma Rectum		INTERVAL BETWEEN ONSET AND DEATH 10 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 23 February, 19 58 , to 5 March, 19 58 , that I last saw the deceased alive on 5 March, 19 58 , and that death occurred at 10:50A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 3-5-58			
ACTUAL SIGNATURE C. W. Bramlett M.D.		U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) C.W. BRAMLETT LT MC USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-10-58	
22c. NAME OF CEMETERY OR CREMATORY Private Cemetery		22d. LOCATION (City, town, or county) (State) Bufallo, New York	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR MAR 10 '58	
24b. REGISTRAR'S SIGNATURE Al. Search			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED J. J. JAMES ()		2. SEX M	
3. AGE 35		4. OCCUPATION None	
5. PLACE OF BIRTH New York		6. DATE OF BIRTH April 1, 1924	
7. PLACE OF DEATH New York		8. DATE OF DEATH April 1, 1959	
9. CAUSE OF DEATH Heart Disease		10. MANNER OF DEATH Natural	
11. SIGNATURE OF PHYSICIAN J. J. JAMES		12. SIGNATURE OF REGISTRAR J. J. JAMES	
13. SIGNATURE OF WITNESSES J. J. JAMES		14. SIGNATURE OF DECEASED J. J. JAMES	

BUREAU V. S.

MAR 10 1959

RECEIVED

3631
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>5520 Greentree Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Agnes</u> Middle <u>Fitzgerald</u> Last <u>Walter</u>		4. DATE OF DEATH Month <u>3</u> Day <u>7</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 26, 1875</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR: Months <u>6</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Fitzgerald</u>		14. MOTHER'S MAIDEN NAME <u>Mary Driscoll</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Charles S. Walter</u>		Address <u>2418 S. 26th St. Arlington, Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Cardiac Decompensation</u> 331X DUE TO <u>Cerebral Hemorrhage & left hemiplegia</u> (b) <u>Cerebroscerosis</u> DUE TO <u>—</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>8 days</u> <u>Undetermined</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Hemorrhage & Partial left hemiplegia (old)</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>—</u> 19 <u>58</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>	
21. I certify that I attended the deceased from <u>Mar 7</u> , 19 <u>58</u> , to <u>Mar 7</u> , 19 <u>58</u> . That I last saw the deceased alive on <u>Mar 7</u> , 19 <u>58</u> , and that death occurred at <u>7:00 P.</u> M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>7835 Eastern Ave., Silver Spring, Md.</u>	
ACTUAL SIGNATURE <u>George L. Ball</u>		DATE SIGNED <u>Mar. 7, 1958</u>	
PHYSICIAN'S NAME (Type) <u>GEORGE L. BALL</u>		<u>Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/11/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>MAR 12 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Deauch</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

REGISTERED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

BUREAU V. A.

MAR 12 1953

RECEIVED

03613

3632

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>4109 Oakdale Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Philip</u> Middle <u>Andrew</u> Last <u>WALKER</u>				4. DATE OF DEATH Month <u>March</u> Day <u>23</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>23 June 1907</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Naval Officer</u>		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Henry G. Walker</u>				14. MOTHER'S MAIDEN NAME <u>Signy Veblen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes Currently</u>				16. SOCIAL SECURITY NO. <u>578 14 8762</u>		17. INFORMANT Address <u>Wife, Mrs. Kathryn G. Walker (Same As #2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage, intracerebral, middle cerebral artery</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>20 March</u> , 19 <u>58</u> , to <u>23 March</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>22 March</u> , 19 <u>58</u> , and that death occurred at <u>7:30 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. J. Mc Carthy</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>U.S. Naval Hospital, Bethesda, Md. 3-24-58</u>			
PHYSICIAN'S NAME (Type) <u>R. J. MC CARTHY, CDR, MC, USN</u>				<u>U.S. Naval Hospital, Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-26-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>St. N. Chambers Co.</u> <u>Chambers, 1400 Chapin St. N.W. Washington, D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 26 1958</u>		24b. REGISTRAR'S SIGNATURE <u>DeLoach</u>	

MEDICAL CERTIFICATION

2

M

51

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

DECEASED

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DECEASED

DECEASED

BUREAU V. R.

MAR 26 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3633

CERTIFICATE OF DEATH

Reg. Dist. No.

03614

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Prince William	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 64 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Pamela Middle Sue Last Wampler		4. DATE OF DEATH Month March Day 1 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 31, 1955
9. AGE (In years last birthday) 2 yrs.		IF UNDER 1 YEAR Months 2	IF UNDER 24 HRS. Days 2 Hours 3 Min. 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Lacy Wampler		14. MOTHER'S MAIDEN NAME Dorothy Street	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c):] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cor pulmonale 756.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchopneumonia DUE TO (c) Fibrosytic disease of the pancreas			INTERVAL BETWEEN ONSET AND DEATH 2 hours 2 months 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 27 19 57 , to March 1 , 19 58 , that I last saw the deceased alive on March 1 , 19 58 , and that death occurred at 5:30 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Ned Feder, MD		DATE SIGNED 3-1-58	
PHYSICIAN'S NAME (Type) Ned Feder, M. D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 3 1958	22c. NAME OF CEMETERY OR CREMATORY Valley View	22d. LOCATION (City, town, or county) (State) Dokesville, VA.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24. REC'D BY REGISTRAR MAR 7 58	
ADDRESS Hyattsville, Maryland.		REGISTRAR'S SIGNATURE W. H. H. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
A CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, place, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. S.

MAR 7 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3478

CERTIFICATE OF DEATH

Reg. Dist. No.

03615

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Takoma Park, Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>		c. LENGTH OF STAY IN 1b <u>17</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		e. STREET ADDRESS <u>814 Carroll Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Harold Ellsworth Warner</u>		4. DATE OF DEATH <u>March 10, 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/7/88</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dr. Philosophy</u>	
11. BIRTHPLACE (State or foreign country) <u>CONN.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Lemuel Warner</u>		14. MOTHER'S MAIDEN NAME <u>Julia Newell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Chart - Wash. San. TR. PK., MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Ac Myocardial Infarction</u> DUE TO <u>Atherosclerosis of coronary artery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Inter</u> DUE TO (c) <u>Inter</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Other previous occlusion 1 yr ago</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/10/1958</u> , to <u>3/10/1958</u> , that I last saw the deceased alive on <u>3/10/1958</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Chas H Wolcott</u> ADDRESS (Street, city or town, state) <u>500 Underwood St NW</u> DATE SIGNED <u>3/10/58</u> PHYSICIAN'S NAME (Type) <u>Chas H Wolcott</u> <u>Washington, D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>3/11/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Southland Md -</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin W. Fusco</u>		ADDRESS <u>1300-N St</u>	
24a. REC'D BY REGISTRAR <u>W. Beach</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	
DATE <u>MAR 12 '58</u>			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03616

3634

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Montgomery</u> b. COUNTY <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>13508 Farthing Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Baby</u> First <u>Boy</u> Middle <u>Wermter</u> Last		4. DATE OF DEATH <u>March 30</u> 19 <u>58</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 29</u>
9. AGE (In years lost birthday) yrs. <u>1 1/2</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>12</u>	
11. IF UNDER 24 HRS. Hours <u>1</u> Min. <u>12</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Raymond Wermter</u>		14. MOTHER'S MAIDEN NAME <u>Adelaide Blake</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Adelaide B. Wermter</u>	
17. INFORMANT <u>Raymond 3508 Farthing</u>		18. ADDRESS <u>Adelaide B. Wermter Silver Spring</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 770.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Erythroblastosis Foetalis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/29</u> , 19 <u>58</u> , to <u>3/30</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/30</u> , 19 <u>58</u> , and that death occurred at <u>6:50 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Maynard I. Cohen</u> M.D.		ADDRESS (Street, city or town, state) <u>March 30, 1958</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>MAYNARD I Cohen</u>			
22. BURIAL, CREMATION, REMOVAL (Specify) <u>4-2-58</u>		22b. DATE THEREOF <u>ARLINGTON CEMETERY ARLINGTON VA.</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy T. Anderson</u>		24. REC'D BY REGISTRAR <u>APR 7 '58</u>	
ADDRESS <u>3831 G.A. Avenue</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>	

APR 7 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3635

CERTIFICATE OF DEATH

Reg. Dist. No.

03617

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE West Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Richwood 85X-3 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NNMC, Bethesda, Md.		d. STREET ADDRESS Baber Route	
3. NAME OF DECEASED (Type or print) First Joe Middle Bryan Last WIBLIN		4. DATE OF DEATH Month March Day 4 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 July 1898
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman, C & O Railroad.		10b. KIND OF BUSINESS OR INDUSTRY Commercial	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William WIBLIN		14. MOTHER'S MAIDEN NAME Susan WHITE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 232 16 6388	
17. INFORMANT (Official Navy Records)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the larynx with metastasis DUE TO (b) 161X DUE TO (c) metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 3 years (approx.)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 27 December , 19 57 , to 4 March , 19 58 , that I last saw the deceased alive on 4 March 1958 , 19 58 , and that death occurred at 9:00 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. R. Pumphrey		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Maryland	
DATE SIGNED 3-6-58			
PHYSICIAN'S NAME (Type) Martin R. PLAUT, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md. 3-6-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9 March 1958	22c. NAME OF CEMETERY OR CREMATORY MC Million Church Cemetery	22d. LOCATION (City, town, or county) (State) Williamburg, West Virginia
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey		ADDRESS 7557 Wisconsin Ave., Bethesda, Md.	
24a. REC'D BY REGISTRAR MAR 7 '58		24b. REGISTRAR'S SIGNATURE W. R. Pumphrey	

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Occupation		Usual Residence		Manner of Death	
Signature of Physician		Signature of Registrar		Signature of Informant	
Date of Registration		Place of Registration		County	
State		City		Zip	

BUREAU V. S.

RECEIVED
MAR 2 1969

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03618

3479

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Alma</u> Middle <u>(Wm)</u> Last <u>Wilkins</u>				4. DATE OF DEATH Month <u>March</u> Day <u>28</u> Year <u>1958</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/3/04</u>			
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>La.</u>			
13. FATHER'S NAME <u>Stephen Hampton</u>				14. MOTHER'S MAIDEN NAME <u>Alma Varneado</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Dr's Chart</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>446X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic nephrosclerosis</u> DUE TO <u>Hypertension</u> (c) <u></u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u> <u>4 yrs</u> <u>4 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>1956</u> to <u>MARCH 18, 1958</u> , that I last saw the deceased alive on <u>MARCH 27, 1958</u> , and that death occurred at <u>9:25 A.M.</u> from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>927 Pershing St</u>				ADDRESS (Street, city or town, state) <u>Silver Spring</u> DATE SIGNED <u>3-28-58</u>					
PHYSICIAN'S NAME (Type) <u>A.W.D. ANISH</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>3/31/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CREMATORY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u> ADDRESS <u>Silver Spring</u>				24a. REC'D BY REGISTRAR <u>W. E. Smith</u> DATE <u>MAR 31 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Smith</u>			

BUREAU

3480

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>33 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hosp.</u>				e. STREET ADDRESS <u>1470 Kanawha ST.</u>			
3. NAME OF DECEASED (Type or print) First <u>Donald</u> Middle <u>Sharp</u> Last <u>Williams</u>				4. DATE OF DEATH Month <u>3</u> Day <u>21</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-24-11</u>	
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>6</u> Hours <u>15</u> Min.		IF UNDER 24 HRS. Months <u>4</u> Days <u>6</u> Hours <u>15</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <u>President - Ex. Equip. Sales.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Pa.</u>			
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>America</u>			
13. FATHER'S NAME <u>Oscar Howard Williams</u>				14. MOTHER'S MAIDEN NAME <u>Elva Sharp</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes Army-WW2</u>				16. SOCIAL SECURITY NO. <u>-</u>			
17. INFORMANT <u>Hospital Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive encephalopathy</u> DUE TO <u>449x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO <u>1 year</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>1958</u> Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>January 8, 1958</u> , to <u>March 21, 1958</u> , that I last saw the deceased alive on <u>March 20, 1958</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Boris Rabin</u>				M.D. <u>1019 University Boulevard</u>			
PHYSICIAN'S NAME (Type) <u>Boris RABKIN</u>				ADDRESS (Street, city or town, state) <u>Silver Spring, Maryland</u> DATE SIGNED <u>3/21/58</u>			
22a. BURIAL <u>Burial</u>				22b. DATE THEREOF <u>March 24, 1958</u>			
22c. NAME OF CEMETERY <u>Riverside Cemetery.</u>				22d. LOCATION (City, town, or county) (State) <u>Norristown, Pennsylvania.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHIMBERS CO., 1400 Chapin St., N.W., Wash. D.C.</u>				24a. RECORDED BY REGISTRAR <u>DC.</u> 24b. REGISTRAR'S SIGNATURE <u>W. W. Chambers</u>			

MAR 24 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3636

CERTIFICATE OF DEATH

03620

Item 17, Film G-226 3/17/58

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3401-4 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HAVAREST NURSING HOME		d. STREET ADDRESS 4623 Old Frederick Rd.	
3. NAME OF DECEASED (Type or print) First HILDA Middle BUCH Last WOOD		4. DATE OF DEATH Month 3 Day 16 Year 1958	
5. SEX F	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 8, 1883
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Minn.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James R. Kearney		14. MOTHER'S MAIDEN NAME Lucy Buch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Dorothy W. Eller, Quarters B, / Mrs. David B. Wallis / 1360 Pentwood Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive failure 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Terminal broncho-pneumonia DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September, 1957 , to March 16, 1958 , that I last saw the deceased alive on March 16, 1958 , and that death occurred at 8:15 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Eino Magi		DATE SIGNED 3/16/58	
PHYSICIAN'S NAME (Type) EINO MAGI		ADDRESS (Street, city or town, state) 918 University Blvd. E., Silver Spring, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/18/58	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	22d. LOCATION (City, town, or county) (State) Balto., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickner & Sons - Balto 17 Md.		24a. REC'D BY REGISTRAR DATE MAR 18 '58	
24b. REGISTRAR'S SIGNATURE W. J. Pickner			

MEDICAL CERTIFICATION

BUREAU V. S.

MAR 18 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3637

CERTIFICATE OF DEATH

Reg. Dist. No. 03621

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Alaska b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 14 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS Box 292			
3. NAME OF DECEASED (Type or print) First Harold Middle Peter Last Woods				4. DATE OF DEATH Month March Day 21 , Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 31, 1935	
9. AGE (In years last birthday) 22 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Common Laborer		11. BIRTHPLACE (State or foreign country) Alaska	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Harold Woods				14. MOTHER'S MAIDEN NAME Adeline Evans			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 574-10-7895		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Heart Disease, Ventricular septal defect. DUE TO and pulmonic valvular stenosis - Post Operative. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Post Operative hemorrhage into mediastinum. DUE TO (c) Congestion of Kidneys. Cardiac Arrest.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 7, 19 58 , to March 21, 19 58 , that I last saw the deceased alive on March 21, 19 58 , and that death occurred at 12:09 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 3/24/58 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE Carlos B. Lombardo M.D.							
PHYSICIAN'S NAME (Type) CARLOS B. LOMBARDO, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-25-58		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) SEWARD ALASKA	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS CO				ADDRESS Wash D.C. 1400 Chapin St N.E.		24a. REC'D BY REGISTRAR MAR 27 '58	
				24b. REGISTRAR'S SIGNATURE W. H. Beach			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, or to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED HARRISON, JAMES		AGE 65		SEX Male		RACE White		RELIGION Roman Catholic		MARRIAGE Married	
DATE OF DEATH October 31, 1958		PLACE OF DEATH Home		CITY Boston		COUNTY Suffolk		STATE Massachusetts		ZIP CODE 02118	
CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		DATE OF BIRTH October 31, 1958		PLACE OF BIRTH Boston		CITY OF BIRTH Boston		COUNTY OF BIRTH Suffolk	
SIGNATURE OF PHYSICIAN J. J. Harrington		SIGNATURE OF DECEASED James Harrison		SIGNATURE OF WITNESS J. J. Harrington		SIGNATURE OF WITNESS J. J. Harrington		SIGNATURE OF WITNESS J. J. Harrington		SIGNATURE OF WITNESS J. J. Harrington	

BUREAU V. 3

MAR 27 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3638

CERTIFICATE OF DEATH

Reg. Dist. No.

03622

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 23 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Richard Middle Hendley Last Wright		4. DATE OF DEATH Month March Day 20 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1.27.09
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance man		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Wright		14. MOTHER'S MAIDEN NAME Mary Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Hospital Records	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Occlusion DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 weeks Prev. Durat.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/26, 1958 , to 3/22, 1958 , that I last saw the deceased alive on 3/19, 1958 , and that death occurred at 4:50 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE [Signature] M.D.			
PHYSICIAN'S NAME (Type) C. H. Ligon, M. D.		Sandy Spring, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/24/58	
22c. NAME OF CEMETERY OR CREMATORY Westview		22d. LOCATION (City, town, or county) (State) Messersville Md	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS Elm - Westernport		24a. REC'D BY REGISTRAR MAR 28 1958	
24b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3639

CERTIFICATE OF DEATH

03623

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WASH. D.C. b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN lb 2 1/2 Months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MAPLE LANE NURSING HOME				d. STREET ADDRESS 4901 9th STREET N.W.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ROSE Middle ADELAIDE Last VOST				4. DATE OF DEATH Month MARCH Day 3 Year 1958			
5. SEX F		6. COLOR OR RACE CAUC		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-28-1870	
9. AGE (In years last birthday) yrs. 87		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GRAND SECRETARY		10b. KIND OF BUSINESS OR INDUSTRY O.E.S.		11. BIRTHPLACE (State or foreign country) WASH. D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JAMES LAVENDER		14. MOTHER'S MAIDEN NAME CHARLOTTE BERGER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 579-12-6449A		17. INFORMANT 5051 NEW HAMPSHIRE AVE. WASH. D.C. HENRIETTA L. ROBINSON			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) ESSENTIAL HYPERTENSION						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from DEC. 14 , 19 57 , to MARCH 3 , 19 58 , that I last saw the deceased alive on MARCH 3 , 19 58 , and that death occurred at 8:30 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Henry M. Bowden M.D.				ADDRESS (Street, city or town, state) 1206 University Dr		DATE SIGNED 3/2/58	
PHYSICIAN'S NAME (Type) HENRY M. BOWDEN				Cherry Chase, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/5/58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gwilius Sons, Inc. ADDRESS 1756 Pa. Ave., N.W DC				24a. REC'D BY REGISTRAR MAR 6 '58		24b. REGISTRAR'S SIGNATURE	

BUREAU V. S.

MAR 6 1958

RECEIVED